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La epidemia de opioides en Estados Unidos: un enfoque basado en los derechos

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La epidemia de opioides en Estados Unidos ha devastado comunidades en todo el país, matando a 70,000 personas en 2017. Las muertes por sobredosis relacionadas con opioides recetados han aumentado desde al menos 1999. La epidemia se propagó en 2010 con un rápido aumento de las muertes por sobredosis de heroína , y se disparó aún más en 2013. Incrementos significativos en muertes por sobredosis con opioides sintéticos como el fentanilo . Si abordamos la epidemia de opioides en los Estados Unidos desde la premisa de que existe un derecho al más alto nivel posible de salud, debemos comenzar por aplicar ese estándar a la epidemia. En otras palabras, ¿qué funciona?

Para prevenir la adicción, la prescripción de menos opioides durante períodos más cortos en dosis más bajas funciona.

Tomar opioides recetados por períodos más prolongados o en dosis más altas puede aumentar el riesgo de adicción, sobredosis y muerte. Los proveedores deben discutir los riesgos de los opioides con sus pacientes, considerar terapias alternativas y, en general, recetar opioides durante períodos más cortos y en dosis más bajas.

Las disminuciones en las tasas de prescripción de opioides desde 2012 sugieren que los proveedores de atención médica se han vuelto más cautelosos en sus prácticas de prescripción de opioides; sin embargo, en 2017, todavía había casi 58 recetas de opioides escritas por cada 100 estadounidenses. Además, el número promedio de días por receta continúa aumentando , con un promedio de 18 días en 2017.

Las formas alternativas de manejo del dolor, como la terapia física, la biorretroalimentación y los medicamentos no opioides, deben suplantar los opioides recetados cuando sea apropiado.

La Guía de los CDC de 2016 para la prescripción de opioides para el dolor crónico tiene recomendaciones que pueden ayudar a mejorar las prácticas de prescripción y asegurar que todos los pacientes reciban un tratamiento para el dolor más seguro y efectivo.

Para salvar vidas, la naloxona funciona.

Un medicamento que puede salvar la vida de una persona que ha tomado una sobredosis de opioides, la naloxona es un medicamento milagroso que es relativamente asequible y fácil de administrar. Tanto las agencias de salud federales como las estatales tienen la capacidad de negociar precios más bajos y ampliar el acceso a la naloxona. También deben alentar su aceptación a través de campañas de educación para la salud pública y mediante el respaldo de farmacias que ya lo ofrecen sin receta en muchos estados. El Congreso puede ayudar a aprobar leyes para proteger a quienes responden que administran naloxona de la responsabilidad, una versión federal de la Ley del 911 sobre el buen samaritano de Illinois .

Para prevenir y tratar, la educación funciona .

A 2015 study by the National Institute on Drug Abuse found that ‘Life Skills Training’ for 12- and 13-year-olds helped them avoid misusing prescription opioids throughout their teenage years. A nationwide health education campaign to counter ignorance and stigma surrounding addiction and medication-assisted treatment, akin to ‘Understanding AIDS,’ the brochure created by the Centers for Disease Control and Prevention in the 1980s and sent to every residential mailing address in the United States, should commence immediately.

Medication-assisted treatment works. “Lock ‘em up and throw away the key” does not.

Nearly 300 law enforcement agencies in 31 states now participate in the Police Assisted Addiction and Recovery Initiative, which offers treatment for drug users who ask authorities for help. Officers work the phones to get people with addictions into treatment and recovery networks, in an effort that costs less and promises more lasting results than repeatedly arresting them.

At the same time, the Drug Enforcement Agency has implemented the ‘360 Strategy,’ which includes not only criminal prosecutions of trafficking organizations, but also partnering with community organizations, schools, pharmaceutical manufacturers, health practitioners, and pharmacists.

Medication-assistant treatment is a form of harm reduction, a public health strategy that aims to diminish the negative effects of opioid use. Methadone, naltrexone, and buprenorphine—the three continuing medication therapies approved by the FDA to treat opioid addiction—help prevent relapse as well as addiction-related medical problems, allowing people to return to work and rebuild their lives. Yet many conventional drug treatment centers in the United States do not offer those treatments and instead provide ineffective, costly, short-term programs with no follow-up.

Treating associated conditions works.

More than 50% of people with substance abuse problems also suffer from depression, post-traumatic stress, or other mental health conditions, rendering them more vulnerable to abuse and relapse. The Mental Health Parity and Addiction Equity Act of 2008 prohibits insurers that cover behavioural health from providing less-favorable benefits for mental health and addiction treatment than the benefits offered for other medical therapies or surgery. Nevertheless, some insurers defy the law, imposing arbitrary treatment limits or onerous authorization requirements. Compliance with the Act is essential to meaningfully address the epidemic.

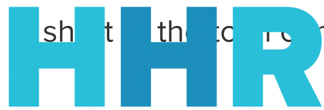
To save lives and fund treatment, Medicaid expansion works.

The Affordable Care Act originally mandated that states significantly expand access to Medicaid. However, in *National Federation of Independent Business v. Sebelius*, the Supreme Court held that the mandatory expansion of Medicaid as written was not a valid exercise of Congress's spending power. Thus it is up to the states to opt in to Medicaid eligibility expansion under the ACA. To date, 36 states and DC have adopted; 14 have not.

The City of Dayton had one of the highest opioid overdose death rates in the nation in 2017 and the worst in Ohio. The county had 566 overdose deaths in 2017 and 294 in 2018, a 54% decline. Credit is due to Governor John Kasich's decision to expand Medicaid in 2015, a move that gave nearly 700,000 low-income adults access to free addiction and mental health treatment. In Dayton, Medicaid expansion has yielded multiple new treatment providers, including residential programs and outpatient clinics that dispense methadone, buprenorphine, and naltrexone.

An epidemic of this proportion requires investment by our government. Notwithstanding the epic proportions of the opioid crisis, both Congress and the President have failed to fund meaningful prevention and treatment to date. The 2018 Support for Patients and Communities

Act continued existing federal funding and incrementally expanded access to care, but falls far short of the commitment needed.



The facts, figures, and rhetoric around the opioid epidemic bear a striking resemblance to the language of the South African Constitutional Court in *Minister of Health v. Treatment Action Campaign* (2002), in which the Court asserted that

> *The HIV/AIDS pandemic in South Africa has been described as an incomprehensible calamity and the most important challenge facing South Africa since the birth of our new democracy and government's fight against this scourge as a top priority. It has claimed millions of lives, inflicting pain and grief, causing fear and uncertainty, and threatening the economy. These are not the words of alarmists but are taken from a Department of Health publication in 2000 and a ministerial foreword to an earlier departmental publication.*

Although the US Supreme Court has yet to hear an opioid case, in 2017 the US Department of Health and Human Services declared the opioid epidemic to be a nationwide public health emergency; overdoses killed more people in 2016 than guns or car accidents, and are occurring at a rate faster than the HIV epidemic at its peak. Like South African in 2002, the United States in 2018 is in a state of crisis due to an entrenched, deathly epidemic. There is no more appropriate time for the federal government to commit resources.

It is true that hospitals, many medicines, and other forms of treatment are expensive. And without a single payer system to bear the costs, access to health care in America is primarily driven by insurance markets. The good news is that our response to the opioid epidemic can be efficient, impactful, and cost-effective, all in a way that maximizes our right to the highest attainable standard of health.

A rights-based approach to health allows us to see clearly what is obscured in America's traditional approach to health care: to crest the arc of the opioid epidemic, the United States must commit resources to proven interventions and the highest attainable standard of care. There is no time to waste.

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