JIED Journal of Illicit Economies and Development

Structural Imperialism and the Pandemic of Untreated Pain in the Asia Region

POLICY COMMENTARY

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LSE Press

ABSTRACT

This paper takes a transdisciplinary genealogical approach to the current global lack availability of internationally controlled essential medicines in more than 80% of the world, with a particular focus on the Asia region. More than six decades after the Single Convention on Narcotic Drugs (SC), whose Parties were "concerned with the health and welfare of mankind," had stipulated that these substancs are 'indispensable' for the relief of pain and suffering, experts report that while the global consumption of opioids has increased, the consumption in most Asian countries has not increased at the same rate and that access is significantly impaired by widespread over-regulation that continues to be pervasive across the region. The tragic irony of this situation is that traditional opium-based medicines used for millennia in the region are unavailable, inaccessible, and unaffordable in these erstwhile imperial peripheries where their botanical sources are plentiful but forbidden, while global pharmaceutical corporations peddle their expensive synthetic opioids — formulated in the metropolis — to formerly colonized populations who cannot afford them and whose health workers are largely untrained to prescribe them.

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KEYWORDS:
Internationally controlled essential medicines; Single Convention on Narcotic Drugs; opium; empire; decolonizing; palliative care; empire

TO CITE THIS ARTICLE:
Pettus, K. 2024. Structural Imperialism and the Pandemic of Untreated Pain in the Asia Region. *Journal of Illicit Economies and Development*, 5(2):pp.92–100.DOI:https://doi.org/10.31389/jied.194

DOI: 10.31389/jied.194

INTRODUCTION

This paper adopts a transdisciplinary genealogical approach to address the current global shortage of internationally controlled essential medicines, particularly focusing on the Asia region, in more than 80% of the world. Despite more than six decades passing since the establishment of the Single Convention on Narcotic Drugs (SC), which expressed 'concern with the health and welfare of mankind,' and emphasized that these substances are 'indispensable' for the relief of pain and suffering, experts now report that

> While the global consumption of opioids has increased, the consumption in most Asian countries has not increased at the same rate. [...] With the exception of Japan and South Korea, opioid availability continues to be low throughout most of Asia. Formulary deficiencies are severe in several countries, in particular Bangladesh, Myanmar, Afghanistan, Kazakhstan and Laos. Even when opioids are on formulary, they are often unavailable, particularly in the same countries. *Access is significantly impaired by widespread over-regulation that continues to be pervasive across the region.* (Italics added; Cleary et al. 2013)

What accounts for this overregulation despite the dismal data regarding the prevalence of serious health-related suffering (Knaul et al. 2018), insistent UN resolutions addressing the topic,[1] and modern developments in regulatory science, clinical medicine, and evidence-based treatment for opioid use disorder in the very same region that produces the lion's share of the raw materials of biological opiates? A transhistorical genealogical approach attempts to answer a question by reviewing the current situation – which in this case is the persistence of officially identified *impediments* to availability – and then by discerning their 'origins,' or perhaps more precisely, the 'soil' from which the situation, including the concepts, laws, and social norms, has developed (Lightbody 2010).

I argue that the impediments reflect the long and durable half-life of structural imperialism, which in the case of global 'narcotics control' began with the commodification of opium by agents of the imperial metropolis (Trocki 2012). Initial reactions against the social harms generated by this commodification on the peripheries came from within the metropolis itself, from reform organizations associated with Anglo-American evangelical movements (Tyrrell 2013), and from bureaucrats in charge of imperial opium revenues (Kim 2021). Reformers infused their respective governments' empire-building impulses with norm-generating anti-vice agendas, while bureaucrats consistently highlighted system inefficiencies and performative contradictions. Those agendas eventually encoded othering cultural stigma around the periphery's use of what were generally known as 'narcotic drugs,' into global norms, laws, and institutional policies on opioids that persist to this day. Postcolonial elites instrumentalized the conferred cultural stigma associated with these substances and persons who consumed them, framed as citizen 'dishonor' in political terms (Pettus 2013) to gain, legitimate, and maintain control in the context of legacy opium monopolies and illicit global drug markets.

> Within countries struggling to transform subject populations into a society of citizens, there was a decided taint to overtly continuing a colonial institution in an era of de-colonization. (Kim 2021)

CURRENT SITUATION IN SOUTH ASIA REGARDING AVAILABILITY OF OPIOIDS FOR MEDICAL PURPOSES

According to the International Narcotics Control Board (INCB), '[d]espite some small improvements, availability for consumption has decreased and remains very inadequate in most countries in Africa *and is inadequate* in most countries in Asia, Central and South America, the Caribbean and Eastern Europe' (Italics added; INCB 2018). Although one academic expert

1 For instance, the most recent UN Third Committee Resolution on the World Drug Problem adopted in December 2022, "*Reiterates* the strong commitment of Member States to improve access to controlled substances for medical and scientific purposes by appropriately addressing existing barriers in this regard, while concurrently preventing the diversion and abuse of and trafficking in such substances, and to strengthen, as appropriate, the proper functioning of national drug control systems and domestic assessment mechanisms and programs, with a view to promoting the health and welfare of humankind" [Third committee resolution December 2022].

concludes 'There has been little increase in opioid consumption in SEARO' (Clark et al. 2021), another analysis (Zin 2020), which examined trends of strong opioid consumption in Malaysia, Singapore, Indonesia, Thailand, and Vietnam, is tentatively optimistic, opining that 'the overall increasing trends of strong opioids consumption in all five Southeast Asian countries *may* reflect the improvement in the access to opioid analgesics.' According to a regional expert interviewed by the author, any increasing trend can be attributed to aggressive marketing by global pharmaceutical companies of expensive brand-name opioids such as oxycontin and fentanyl. The generic gold standard (according to the WHO) of pain management, oral morphine, made from opium poppies, is largely unavailable as it is unprofitable for pharma companies to manufacture, register, and market.[2] Expert consensus seems to be that 'there are vast disparities in cancer pain management practices and access to opioids in the Southeast Asian countries and that [....] cancer pain is being generally undermanaged.'

> Access to opioids is inadequate in most countries, and opioid use for analgesia remains inadequate in the region. Several system-, physician-, and patient-related barriers to adequate pain relief were identified, including widespread over-regulation of opioid use, shortage of trained health care workers, inadequacies in pain assessment and knowledge about managing pain, and widespread resistance among patients and physicians toward opioid treatment. (Javier et al. 2016)

According to the INCB (2018), factors unduly limiting the availability of controlled substances for scientific and medical purposes include (1) fear of addiction, (2) a lack of training among health personnel, (3) a lack of awareness among patients and families, and (4) lack of demand for pain treatment. Analytically speaking, fear of addiction is rooted in a lack of evidence-based training among health personnel and lack of awareness among patients and families, an epistemic gap whose genesis is widespread opioidphobia and generations of cumulative cultural stigma attaching to opioids and people who consume them, including for prescribed medical use.[3] (Graphic Richards et al. 2022: 37)

The following section, which provides a brief historical overview of the roots of cultural opioidphobia, is followed by a theoretical discussion of the stigma system and its political instantiation as fear of dishonor and punishment as these relate to the availability of internationally controlled essential medicines. It is unnecessary to rehearse the excellent contemporary social science scholarship on the history of the drug control regimes with which most readers will be familiar already.

MERCANTILIST AND IMPERIAL ROOTS OF THE AVAILABILITY CRISIS

In James Hevia's (2003) words,

> Opium was, in the nineteenth century, one of the most empire-friendly commodities circulating in the global economy. It had the capacity to balance imperial books, attract a seemingly endless number of customers, and, in a world where cargo space, like time, was money, take up little if any of the room on the ships of merchant princes, smugglers, and pirates.

Before the United States and Chinese led opium suppression campaigns at the turn of the 20th century, opium was the legal and extremely profitable coin of the realm – literally – of the European empires. 'Without the drug,' according to economic historian Carl Trocki, 'there probably would have been no British Empire' (Trocki 2012). Empires, by (dependency theory) definition, are constituted by a metropolis and periphery (Milios & Sotiropoulos 2009). The metropolis, or 'core,' operates with virtual impunity regarding the welfare of subjects of the periphery who, again by definition, are subjects, non-citizens. As such, they are a disenfranchised

2 Expert informants in Singapore, Thailand, Myanmar, and Malaysia have told me that locals who know where to look for pain relief can find opium gum in the markets, often at traditional Chinese pharmacies. One palliative care doctor told me that his patients tend to prefer it to the pharmaceutical opioids he prescribes for them, even when these can be found. It would be helpful to have more research on these parallel markets.

3 The evidence shows that focused training programs for professionals and awareness-raising campaigns can mitigate opioid or opiophobia (Bosnjak et al. 2016).

population devoid of attributed dignity,[4] citizen honor, and rights. A premise of this argument is that the imperial periphery's half-life extends beyond formal independence and legal incorporation into the United Nations organizations as sovereign nation-states. It extends not only into the polity – into laws and regulations that are hangovers from the imperial era, but also into local practices and prejudices, including in the academy, into sites of public health knowledge production and reproduction, thereby feeding an epistemic, abyss (Pettus 2019). As Radhika Mohanram (1999: 200–220) says,

> Place is of tremendous importance within postcolonial discourse [...] Colonialism was about the seizing of place, draining it of its resources, its history, and the meaning attributed to it by its primary occupants. The centrality of place is made visible in postcolonial discourse by its interrogation of the meaning of locations, the excess or lack of resources in these locations, the equitable sharing and withholding of resources.

The issue under consideration, the 21st-century *cartography of pain*, maps almost seamlessly onto the cartography of colonialism from the 16th to 20th centuries, and more precisely to the commodification of opium that generated enormous profits for the metropolis in the 'Far East' periphery of the British Empire. While modern citizen rights in the metropolis include the right to health, with pain control and basic medical treatment (proving that this is possible under the current global drug control system), they *remain* a chimera for the denizens of the periphery, pointing, in other words, to factors other than just laws and regulations, which can be changed with the requisite political will. Claiming rights entails agency and to paraphrase Hannah Arendt, the right to have rights, one postcolonial subjects in the former periphery have yet to enjoy to the fullest.[5] Although the imperial era came officially to an end with the decolonization and independence of most subject territories in the 20th century, post- or neo-colonial theories have explanatory power regarding the unavailability of medicines governed by the SC.

Zooming out from the world system into the local situation, Diana Kim (2021) – who painstakingly tracked the discourse of colonial bureaucrats throughout Southeast Asia – argues that vice taxes themselves – which produced the profits derived from the peripheries of the metropolis – eventually undermined the legitimacy of the various imperial opium trades. Yet an unintended consequence of that delegitimizing movement spearheaded by the global elite movements of reformers and civil servants, *in both the metropolis and periphery*, was their signal failure to develop the requisite normative, technical, and regulatory structures to support medical and scientific use in the peripheries (Husain et al. 2013; Krakauer et al. 2015). This apparent administrative oversight, the source of the 'access abyss,' compared to the detailed compendium of law restrictions that governed prohibition of non-medical use both in the Single Convention and in the ancillary texts and national laws, tipped the balance against availability and reflects the epigenetic *and epistemic* damage of the imperial gaze.[6] Postcolonial theory refers to the longevity of the original colonial relation because its unrepaired legacy continues to negatively impact the descendants of both the denizens of the periphery and the citizens of the metropolis through elite institutions such as the academy. When both sets of persons are simultaneously integrated into one polity as 'citizens' (post-independence for instance, or in the world-system as sovereign nations) then the polity suffers from the unexcavated or unacknowledged legacies set in motion by the original process of domination.

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4 Attributed dignity is distinguished from intrinsic dignity, which cannot be destroyed. "By *attributed* dignity, I mean that worth, stature, or value that human beings confer upon others by acts of attribution. The act of conferring this value may be accomplished individually or communally, but it always involves a choice." See Sulmasy, DP. 2008. Dignity and bioethics: history, theory, and selected applications. *Human Dignity and Bioethics*, 1: 469–501.

5 For a useful discussion of postcolonial elites' domination of political and global health, see Keshri, VR. and Bhaumik, S. 2022. The feudal structure of global health and its implications for decolonisation. *BMJ Global Health*, 7**:** e010603.

6 See for instance Knaul, FM., Rosa WE., Arreola-Ornelas, H., and Nargund, RS. 2022. Closing the global pain divide: Balancing access and excess. *The Lancet Public Health*, 7(4): e295–e296. "[T]he 'access abyss' in pain relief is clearly fed by the 10–90 partiality of the literature, reflecting the imbalanced attention towards opioid abuse and misuse compared with the pain pandemic by the scientific community—itself a reflection of maldistributed research funding and scholarly prioritisation."

In Diana Kim's (2021) detailed analysis of the *postcolonial* period in the opium-producing periphery,

> Punishment displaced prohibition as the common language by which rulers across Southeast Asia affirmed their proper role concerning opium. In a familiar shadow of the near past, an official vocabulary congealed, one through which actors in privileged positions of government arrogated an authority to wield extraordinary powers, citing exceptional obligations to protect people. Declared penal imperatives did not serve to merely mask or distract attention from simple corruption. Rather they gave expression to unresolved inconsistencies and deep tensions that those tasked with governance inherited, struggled with, and reproduced constantly.

Chronic 21st-century unavailability of opioids for medical and scientific purposes in the Asian region is the collateral damage of those still unresolved inconsistencies and deep governance tensions. The following section provides a theoretical perspective on the public health harms that result from these inconsistencies and governance tensions that are reproduced to this day through the culturally entrenched stigma system (Friedman et al. 2022).

CITIZEN HONOR, OPIOIDPHOBIA, AND CULTURAL STIGMA

Since the former subjects of the colonial metropolis are now, at least legally, citizens of modern independent nations who are members of a rules-based international order, human rights law as well as recent high-level multilateral declarations have stipulated that people suffering from drug use disorders and patients who need opiates for medical purposes are entitled to evidence-based services and treatments. The abyss in access and availability detailed above is one expression of the prevalence of the modern stigma system in public health practice. Stigma systems such as that pertaining to 'narcotic drugs' encode culturally institutionalized negativity surrounding opiates, addiction, terminal illness and dying, into social norms, national laws, and regulations around the availability of medicines. The modern stigma system generated by the imperial commodification of opium and the subsequent reform movements transformed what millennia was a substance honored by indigenous communities for ceremonial and medical use into a 'drug' whose unsanctioned use is, in some countries, punishable by state-imposed death sentences.

Governing elites in modern postcolonial states have succeeded in instrumentalizing the 19th–20th century stigma system that developed around narcotic drugs to maintain political power, privilege, and wealth. Stigma among other things is a modern sociological expression of the inverse of classical – *political* – notion of citizenship honor. This notion was originally constituted in Greco-Roman political theory by valor, productivity, and measurable contributions to the polity through courageous military service and law-abiding behavior.

Dishonor, or disenfranchisement, was the severe *official* penalty incurred for infringing laws mandating trustworthy and courageous behavior, such as showing up for compulsory military service (Pettus 2013). Since recreational drug use (particularly in the Asian region) has been culturally constructed as the antithesis of courageous and trustworthy behavior, people who use drugs and even patients who need opiates for the management of chronic pain and palliative care are, in this analysis, stigmatized and unworthy of the status honor of citizenship. Honor constituted by attributed citizen virtue is a distinctly political attribute, in contrast with the closely related concepts of attributed esteem, or dignity, which are not necessarily political. The stigma system effectively dishonors and marginalizes people perceived to be drug dependent, subjecting them to the penalty of civil, if not physical, death (Patterson 1985).

Palliative care and harm reduction services, both non-stigmatizing, and in fact self-consciously *anti*-stigmatizing, movements that ensure patient-centered care for people in need of opiates for medical and scientific purposes, restore and nourish the *honor* of drug-dependent and seriously ill citizens who, otherwise deprived of citizen honor by dominant norms, are de facto rendered slaves, exiles, or prisoners, experiencing "social death" (Patterson 1985) before dying physical deaths in what in the 21st century has rendered clinically preventable suffering. Dismantling the stigma system and ensuring that internationally controlled essential medicines are available for those who need them entails dusting off the virtues of solidarity embodied in classical republican citizenship: civic friendship, courage, honesty, and magnanimity, in order

to activate the *praxis* necessary to restore the honor and individual rights of these vulnerable cohorts of democratic citizens.

The cumulative benefits accruing to governing elites through the stigma system can explain its longevity and resilience around evidence-based opioid availability for medical and scientific purposes. It can also explain the reciprocal detriment to citizens in stigma-affected systems even in the face of official censure from the global scientific and humanitarian communities. Supplementing the stigma system and citizen honor approaches with the theory of 'path dependence' or increasing returns – a theoretical perspective from the discipline of economics – (Pierson 2000) can help explain why the availability monitoring needle remains stubbornly stuck at 'low to inadequate' availability of opioids for medical and scientific purposes in the global south, the former European and Soviet colonies or spheres of influence, now nominally independent and equal member in the United Nations.

CONCLUSION: MISPERCEPTIONS AND THE WAY FORWARD

As we saw above, decades of (cumulative) stigma around 'narcotics' and the 'evils' of addiction have colored, indeed stained, the way politicians, the public, administrators, and clinicians perceive essential controlled medicines. Yet an exegetical exercise *free* of the influence of cultural stigma, performed by an academic institute of researchers (Husain 2013) concluded the following, which points to a way forward *based on international law*:

> In terms of drug control, the Single Convention has a very limited number of broad compulsory control measures regarding the therapeutic use of relevant medicines, such as:
>
> - Governments must adopt legislative and administrative measures to limit exclusively to medical and scientific purposes all manufacture, distribution, and possession within the country, (Article 4)2
> - All persons and enterprises involved in import, export, production, manufacture, trade, and distribution must be controlled under government license, (Articles 29, 30)2
> - Quantities manufactured and exported must be within the quantities of drugs required for medical and scientific purposes, as officially estimated by governments and confirmed by the INCB, (Articles 12, 19, 21)2
> - Governments must report the amounts of opioids imported, exported, manufactured, and consumed (distributed to the retail level) to allow the INCB to examine governments' compliance with the Single Convention, (Article 20)2
> - Possession of drugs is not permitted except under legal authority; (Article 33) therefore, medical prescriptions from duly authorized persons are required for dispensing to individuals (e.g., patients; Article 30)2, and
> - Records of acquisition and disposal are to be kept by governmental authorities, manufacturers, traders, scientific institutions, and hospitals. (Article 34)2

Ironically, a common (stigma-based) perception of policymakers, drug regulators, clinicians, administrators, and civil society reformers alike is that the Single Convention details complex, specific, and punishable requirements regarding control of opiates for medical use by which governments and regulators must abide. On the contrary, there is great latitude about how a government can design the drug control system, including growing five tons of poppy for domestic use annually without seeking permission from the INCB (Morris, Smith, & Le Cour Grandmaison 2019; UN 1961).

The first (very tall!) order of business recommended for improving access is closing the stigma-based epistemic gap around opioid prescribing and use for rational medical purposes through routine professional training of medical practitioners including pharmacists, nurses, doctors, and medical officers. Practitioners, drug regulators, and public health officials are all well aware that a surfeit of *prescription* and trafficked opioids – a situation the North American opioid crisis has highlighted in tragic relief – (as opposed to opioids that have been legally *prescribed* to patients by appropriately trained practitioners within evidence-based guidelines) in the health

system can produce harmful dependence in individuals and dependence prone populations without indicated medical conditions (Humphreys et al. 2022; Scholten 2017). Palliative care professionals are the first to advocate for appropriate training, well-regulated supply chains coordinated with the private sector and "narcotics police," and appropriate record keeping with rational institutional safeguards such as lockboxes and dispensing protocols. Indeed, the principle of balance, which promotes adequate availability while avoiding diversion and non-medical use (Pettus et al. 2018), addresses these dual concerns of health professionals, palliative care, surgery, and addiction specialists alike. To date, the private and charitable sectors have subsidized education and training in the majority of countries on a shoestring, especially the global south, which is why progress has been so slow and intermittent.

The historical and cultural tragedy, which overlays the individual tragedy of every patient that dies in preventable pain and the suffering of witnesses and "non-decedents," including healthcare personnel, is that communities and cultures at the heart of the global pandemic of untreated cancer pain (ESMO 2013) such as most in the Asian region, have all but lost their traditional relationships with plant-based medicines that relieve severe pain. National laws forbid the cultivation of their sources for medical purposes, although international law does not, and severely restricts access to the preparations derived therefrom. National laws and regulations erroneously either ban or strictly police traditional life-sustaining relationships with pain-relieving plants and closely oversee modern health providers' relationships with their powerful contemporary pharmaceutical descendants such as morphine (Aggarwal & Pettus 2017). More technical health law advocacy is necessary at all levels of governance concerned with the regulation of opioids for medical purposes to clarify the international normative framework and generate the requisite political will to draft and fund evidence-based enabling legislation requiring governments to relieve the severe health-related suffering (Knaul et al. 2018) of their populations.

The staggering irony is that traditional opium-based medicines are unavailable, inaccessible, and unaffordable in the erstwhile peripheries where their botanical sources are plentiful but forbidden, while global pharmaceutical corporations peddle their expensive synthetic opioids – formulated in the metropolis – to formerly colonized populations who cannot afford them and whose health workers are largely untrained to prescribe them.

COMPETING INTERESTS

The author has no competing interests to declare.

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TO CITE THIS ARTICLE:
Pettus, K. 2024. Structural Imperialism and the Pandemic of Untreated Pain in the Asia Region. *Journal of Illicit Economies and Development*, 5(2):pp.92–100.DOI:https://doi.org/10.31389/jied.194

Submitted: 26 January 2023
Accepted: 07 November 2023
Published: 23 January 2024