Frequently Asked Questions about the Stanford-Lancet Commission on the North American Opioid Crisis

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What is the purpose of this Commission?

The Commission's purpose was to assemble essential evidence on the status of the opioid crisis in the U.S. and Canada and present evidence-based strategies for ending it.

Who is on this Commission?

The Commission comprised 17 members, 10 of whom are clinicians and scholars based at Stanford University and the rest of whom are based elsewhere in the U.S. and Canada. The expertise on the Commission is highly diverse, ranging across addiction, law, neuroscience, pain medicine, public health, primary care, psychiatry, and emergency medicine. The Commission includes members who are current or former government policy makers; members who work caring for patients with addiction, pain, or both; and members who have experienced chronic pain and/or addiction.

How serious is the opioid crisis in the U.S. and Canada?

Over the past quarter century, the U.S. and Canada have lost more lives to overdose than they did in World Wars I and II combined. Millions of individuals have become addicted to opioids triggering increases in other disorders, disability, family breakdown, unemployment, and child neglect. The CDC estimates the annual cost of the crisis in the US at one trillion dollars.

Does the Commission believe the opioid crisis is getting worse?

The Commission's statistical modelling work predicts that in the absence of policy change, 1.22 million Americans will die from opioid overdose from 2020-2029. This is more than died since the crisis started. This worsening is due both to COVID making the opioid crisis more severe, the spread of potent synthetic opioids like fentanyl, and, insufficient investment in policies that can reverse the course of the epidemic of addiction and overdose.

How did the Commission conclude the opioid crisis started?

The Commission concluded that the crisis started when opioid manufacturers like Purdue Pharma aggressively pushed to increase per capita prescriptions in the U.S. and Canada by 400% over a decade. But opioid manufacturers' ability to do this came about in part because regulators (e.g., the Food and Drug Administration, the Department of Justice, the Joint Commission), legislators, health care systems, and health professionals did not adequately resist them. There is thus plenty of blame to go around for the North American opioid crisis.

What are the Commission's recommendations to reduce the pharmaceutical industry's ability to cause overprescribing of addictive medications?

In 2016, the pharmaceutical industry spent USA$20.3 billion marketing its products directly to prescribers, which was more than quadruple the entire budget of the Food and Drug Administration. The fraudulent promotion of OxyContin to prescribers as less addictive than other opioids was a critical reason why that drug became such a problem. The Commission therefore recommends that direct

marketing of drugs to doctors be banned. The Commission also endorsed Congressional proposals to remove the tax deductibility of pharmaceutical marketing both to prescribers and to the general public.

The Commission also recommends that medical, dental, nursing, and pharmacy schools only accept donations from industry that go into a "hands off" common educational fund and that none of their educational programs be influenced in any way by industry wishes. It further recommends that state medical boards and health care accreditation bodies refuse to accept any funding from the pharmaceutical industry.

The Commission also recommends constraining the enormous political influence of the industry by legally defining "astroturfing" (funding allegedly independent patient advocacy organization to carry the industry's message) as a form of fraud, requiring industry to annually disclose all donations to advocacy groups, and restoring limits on corporate contributions to political campaigns.

What does the Commission recommend for the Food and Drug Administration?

The Food and Drug Administration approved OxyContin with a label which included the fraudulent claim the drug was less addictive than other opioids, and did not sufficiently weigh the likelihood that the medication would be widely diverted and misused. The FDA official who oversaw that decision subsequently accepted a high salary position at Purdue Pharma. The Commission concluded that there is no reason a similar sequence of events could not happen again with another addictive medication in the future, and therefore recommends multiple reforms.

First, the FDA should be required to more heavily weigh the risks of addictive drugs being diverted when they make approval decisions. FDA and other regulatory agencies should also be subject to stronger rules closing the "revolving door" in which officials who grant favorable decisions to industry are subsequently allowed to take lucrative positions in industry.

Second, the Commission believes that current law, which tasks the industry itself with conducting monitoring of medication risks after approval and with designing risk mitigation strategies for prescribing, is fundamentally flawed. These activities work against the profit motives of industry and industry has done a poor job completing them, with little sanction by the FDA. The post-approval responsibility to protect the public from risky medications should be taken away from industry and moved into the government, either into the FDA or another federal agency.

What does the Commission recommend about the care of chronic pain?

Commissioners universally see opioids as essential medications that can be provided in ways that reduce pain and maximize function. Getting rid of prescription opioids would do great harm; the goal should instead be to prescribe them judiciously only for those patients who will benefit from them. The Commission notes that the Obama Administration developed a comprehensive National Strategy for Pain that was not sufficiently funded and implemented, and recommends that the Biden Administration revive this strategy.

The Commission also recommends that state and federal lawmakers, health care systems, and individual clinicians bear in mind the diversity of the patient population when designing laws and guidelines for opioid prescribing. Rigid prescribing rules that benefit some subpopulation of patients can inadvertently harm others.

What does the Commission recommend for improving treatment of addiction?

The Commission noted that addiction has been a public health and safety challenge for decades, even though the drug of concern changes over time. It therefore recommends that rather than attempt short-term patches to the health care system, policymakers should make a significant and permanent commitment to funding health care for addicted individuals. Such care should be based in evidence, be integrated with mainstream health care, and be accessible to the entire population regardless of who they are or where they live. Accomplishing this will require all states to expand Medicaid and will require Congress to expand Medicaid coverage in correctional facilities as envisioned in the proposed Medicaid Reentry Act. The Commission also calls on federal and state health insurance regulators to vigorously enforce "parity" laws requiring coverage of addiction treatment by private insurers.

How does the Commission think the criminal justice system should respond to people who are addicted to opioids?

The Commission reviewed evidence indicating that incarcerating individuals for the possession of illicit opioids or drug use equipment (e.g., syringes) for personal use does more harm than good. It therefore recommends banning this practice. Similarly, it recommends ending criminal punishment of pregnant women who use drugs, and, repealing lifetime bans on the housing, employment, and education of people who have had drug problems in the past. The Commission also recommended that all correctional facilities provide a full complement of addiction treatment services to inmates in need.

Could the North American opioid crisis spread to other countries?

Yes. The Commission believes that just as the tobacco industry went overseas in search of new customers when the US began to constrain its activities, the opioid industry will attempt the same thing. Journalists have reported aggressive efforts of U.S.-based manufacturers to employ the same promotional tactics used in the US in a range of countries, including India, Brazil, The Philippines, China, Egypt, and multiple European nations. The Commission therefore advocates that court judgements and laws constraining the conduct of US-based opioid manufacturers and their owners apply globally and not just in the US. It also recommends that to avoid forcing low income countries into the arms of for-profit manufacturers to secure adequate pain and palliative care, that generic morphine be distributed by donor nations to hospitals and hospices in low-income nations that lack a supply of pharmaceutical opioids.