



## The Pain Points of Opioid Policy

The federal government is pushing some modest reforms in its fight against the opioid epidemic, but what will it really take to defeat addiction?

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“It must be total war in every city, town, and village throughout the land,” President Harry Truman [exhorted](#). “For only with a united front can we ever hope to win any war.” With this call to arms, in a 1946 speech just months after the end of World War II, Truman propelled the United States toward war with a new enemy. An ancient scourge had erased millions of lives, permanently ruined several others, and had even forever scarred a president. That enemy was polio, and over a few decades the country would go on to eradicate it entirely.

Almost exactly 70 years later, President Barack Obama, in an ad-lib during his State of the Union address, would name another new enemy, this time “drug abuse and heroin abuse,” thus officially setting the table for a new war. Unlike Truman’s campaign, there is little hope of developing a vaccine for addiction and the exact causes of the epidemic are fuzzy, but he and legislators have pressed forward in one of the only true bipartisan efforts in the country. Just

months since that address, the first policy mobilizations on the new front have emerged. But are they really enough to claim victory?

The urgency of the opioid crisis seems to have broken through congressional gridlock, at least. In March, the Senate passed the Comprehensive Addiction and Recovery Act (CARA), which [sailed through with only one dissenting vote](#). The Act authorizes—but doesn't appropriate—more than \$700 million in funds for prevention programs, task forces for prescription best practices, and prescription-monitoring programs. It also expands access to the drug naloxone, which is used to counteract overdoses.

The bill has a number of vocal supporters on both sides of the political aisle, including Senators Kelly Ayotte from New Hampshire and Rob Portman from Ohio, both Republicans. Their home states illustrate the true depths of the country's struggle with addiction. Both Ohio and New Hampshire [rank among the top-five states](#) in age-adjusted mortality rates for drug overdoses, at 24.6 and 26.2 deaths per 100,000 members of the population, respectively. Between 2013 and 2014, [New Hampshire's death toll grew by an astounding 75 percent](#). Ayotte and Portman are front-line fighters against a wave of opioid deaths, and several senators have rallied behind their banners.

But with that broad support comes an important caveat: Without proper funding, CARA could be toothless, even if it passes the House. Democrats almost stalled the bill's passage because of Republican resistance to an additional \$600 million funding package, which was dropped. Even that beefed-up investment might have been paltry in comparison with the true costs of the opioid epidemic now gripping America, which is responsible for [at least \\$25 billion in health costs alone](#) every year.

As the commander-in-chief of this war, President Obama is pressing forward as well. His 2017 budget calls for [\\$1.1 billion to help fight the opioid epidemic](#), most of it in arrangements with states to expand access to naloxone. He has also leveraged the executive branch to expand access to medication-based treatment, expand access to mental-health and drug-abuse treatment for Medicaid patients, and expand community policing in addressing heroin distribution.

Even if both ideas are woefully underfunded relative to the magnitude of the crisis, Obama's budget would ideally complement the Senate's, matching its focus on prescription-drug control with a more immediate life-saving investment to directly halt drug overdoses, a combination that fights both sides of the continuum that oscillates to create this crisis. But that relationship relies on passage and full appropriation for both the bill and the budget, a prospect that even with extraordinary bipartisan support seems unlikely given recent history.

The greater history of public health offers some hope. After World War II, the country threw itself into a multifront public-health campaign, pouring public, private, and philanthropic resources into vaccine research; establishing agencies like the Centers for Disease Control, which has become the face of American public health; expanding the National Institutes of Health; and generally establishing a strong precedent of public health as the provenance of the federal government. The Public Health Service Act, passed by Truman's predecessor Franklin Delano Roosevelt in 1944, brought disparate public-health bodies under the aegis of wartime

coordination and precision—and [doubled their budgetsblend of fundingJonas Salk discovered the superweapon vaccine](#) to fight polio in 1952. The twin policies of Medicare and Medicaid, [programs that Truman championed](#), were signed into law by Lyndon B. Johnson in 1965, partially completing the circle of public health and public insurance.

In just decades after Truman’s speech—an instant in the history of disease—the country had not only vanquished polio, but had beaten back malaria and smallpox. As it matured into a global superpower, America had also reached a level of public-health sophistication that had never before been seen in the world and had shaken off the specters of three of mankind’s biggest killers.

Partly because of that public-health revolution, partly because of lingering inequalities, and partly because of the evolution of politics, President Obama will find it much more difficult to fight this public-health war. The chronic-disease challenges we face now, unlike infectious disease, can’t usually be avoided by something as easy to mandate as inoculation, and they often involve much more complex social and sociological etiologies and outcomes. The nation’s failure to pass true universal health care and its subsequent disinterest in those who fell through the cracks have hamstrung its ability to act as a coordinator. Its previous public-health war, the War on Drugs, took a counterproductive and carceral stance—locking up illegal-drug users and dealers and rarely stopping to address the mental-health and socioeconomic factors that fueled the crisis. [And it likely promotes](#) the kinds of black markets and drug-choice escalation that lead to sudden spikes in overdoses. By budget, at least, President Obama [is still fighting that war](#).

Opioid abuse stands as the inevitable scion of all of those public-health issues. A profoundly fragmented health system and insurance structure allow for a climate of perverse prescribing and drug-seeking behaviors, with few options to stop it. The War on Drugs has only served to further marginalize and isolate drug use from the assistance that is available. And decades of race-based criminalization of drug abuse have stunted and ossified response options, a consequence that has proved hard to shake, even as the face of the epidemic has become whiter.

So, against those obstacles, how does the federal government fight the “total war” that Truman prescribed as a public-health response? The early legislation and budget provide some embryonic examples of what might be necessary. The first and most obvious checkpoint is expanding health insurance and increasing what it can and will cover for mental health and substance abuse. The second is a dramatic overhaul in how doctors prescribe drugs and how prescriptions are coordinated and monitored. The third is expanding immediate treatment and first-response options for overdose.

Ironically, the tidiest proposal that could meet all three of these goals is Truman’s pet policy, some sort of universal-health-care or public option. But that would just be a part of the “total war” approach of leveraging every asset possible. Also, these goals cannot fully exist in a perpetually underfunded climate of criminalization.

“If we fail to recognize the inherent danger of this disease, we overlook a threat to the people of the United States,” Truman noted in that radio speech in 1946. This is the kind of seriousness that the opioid epidemic merits, and the wide-scale mobilization of mid-20th-century American

public health is a useful model for addressing that seriousness. CARA and the president's budget provide a beachhead for that response but will fall short unless reinforced. That reinforcement will require a broad multifaceted and well-funded effort that seems antithetical to the current atmosphere of tribal gridlock. Is the government really ready to go to war?