

# "The Politics of Pain": A Comparative Analysis of the Opioid Crisis in the United States and France



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## **Abstract**

This article addresses the critical question of how the divergent strategies employed by the United States and France have influenced their respective outcomes in combating opioid addiction. Despite the challenge of opioid overuse—a pressing global health crisis that has led to widespread social and personal suffering—the United States and France have pursued markedly different response efforts, leading to noticeable disparities in mortality rates and the overall impact of the crisis. Whereas the United States has escalated its response to a national emergency level, France has approached the issue with a suite of policies and interventions, viewing it as a significant public health concern. By conducting a thorough review of government policies, healthcare system responses, and harm reduction strategies within both contexts, this study argues for the potential benefits of integrating certain aspects of France’s approach into the United States’ strategy to forge a comprehensive and adaptive response to the evolving opioid crisis.

## **Keywords**

Opioid Crisis; Public Health Policy; Harm Reduction Strategies; French Healthcare System; Opioid Mortality Rates; Pain Management Policies; Substance Use Disorder Treatment; Medication-Assisted Treatment; Comparative Healthcare Analysis; Opioid Prescribing Practices

## **The Opioid Epidemic**

In an era marked by unprecedented challenges emerges a crisis of staggering magnitude, unparalleled in history—the relentless scourge of drug overdose by opioids. Sweeping across continents, it has cast a shadow of tragedy and despair. In the United States, the Centers for Disease Control (CDC) estimates that 115 Americans die every day from opioid overdose, and between the years 1999 and 2021, more than 645,000 people died from opioids—more than gun homicides and car crashes combined.<sup>1</sup> Since 1999, the number of opioid overdoses in America has nearly quadrupled from 1.5 deaths to 5.9 deaths per 100,000 people,<sup>2</sup> and without coincidence, remains equal to the number of opioid prescriptions distributed. The crisis does not stop at American borders. Between 1991 and 2013, global consumption of opioid analgesics increased by 618 percent.<sup>3</sup> In addition to millions of preventable deaths, millions more have been impacted by the issues surrounding it, such as homelessness, joblessness, and family disruption. Without intervention, a predicted 1.2 million preventable deaths will occur in the U.S. by the decade’s end. In response to these alarming statistics and as the problem remains more relevant than ever, nations across the globe continue to adjust and refine their policies to combat the devastation of the opioid crisis.

This article delves into the complex dynamics between historical progressions, policy measures, healthcare infrastructure, and societal views on opioid consumption; it explores how these elements have uniquely shaped the United States and France’s approaches to the opioid dilemma. It analyzes the comprehensive strategies employed by each country in addressing this crisis, specifically

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<sup>1</sup> "Opioid Basics: Understanding the Epidemic," *U.S. Centers for Disease Control and Prevention*, last modified August 8, 2023, <https://www.deadiversion.usdoj.gov/schedules/schedules.html>; President of the United States, *The President's Commission on Combating Drug Addiction and the Opioid Crisis*, (2017): 115, <https://purl.fdlp.gov/GPO/gpo119727>.

<sup>2</sup> Choukri Chenaf, "Prescription Opioid Analgesic Use in France: Trends and Impact on Morbidity–Mortality," *European Journal of Pain* 23, no. 1 (2018): 125.

<sup>3</sup> Jane Pryma, "Technologies of Expertise: Opioids and Pain Management’s Credibility Crisis," *American Sociological Review* 87, no. 1 (2022): 17.

deriving insights from France's methodology. These insights will be assessed for their potential applicability to the U.S. with the objective of enhancing its response to the opioid epidemic. Both nations present a compelling case for comparison due to their historically high rates of prescription opioid usage and their proactive stances on pain management as a critical public health concern. Yet, their paths diverge significantly: the U.S. recognized the opioid crisis as a national public health emergency in October 2017, while France saw a peak in opioid-related fatalities in the 1990s, followed by a rapid decline to stable levels, thus shifting the public's focus. The variance in results over time is largely tied to each country's unique blend of socio-political-economic backgrounds and the specific countermeasures implemented. France's success, attributed to its stringent legal policies and established harm reduction strategies, underscores the importance of a detailed comparative study.

In the late 19th century, both the United States and France encountered challenges with opioid dependence, a phenomenon ignited by the rapid advancements in pharmaceutical manufacturing. During this period, opioids were celebrated as a cornerstone of medical innovation, offering unprecedented relief for a spectrum of conditions from combat-related injuries to common diseases. However, the turn of the century saw a rise in opioid dependence and its dangers, and federal regulations and medical education were implemented in both nations to eventually contain and successfully curtail the epidemic's spread. Yet, at the end of the twentieth century a pivotal transformation in the medical community's approach to pain management emerged. Spearheaded by the American Pain Society's endorsement of pain as the "fifth vital sign,"<sup>4</sup> this paradigm shift underscored the importance of pain assessment in clinical evaluations, consequently precipitating a resurgence in the prescription of opioids.

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<sup>4</sup> Clara Scher, Lauren Meador, Janet H. Van Cleave, and M. Carrington Reid, "Moving Beyond Pain as the Fifth Vital Sign and Patient Satisfaction Scores to Improve Pain Care in the 21st Century," *Pain Management Nursing* 19, no. 2 (2018): 125.

The opioid epidemic, as it is understood today, has developed through three interlinked waves, each magnifying the severity and reach of the crisis to unprecedented levels. Initiated in the late 1990s, the first wave was characterized by the excessive prescribing of opioid pain relievers. The introduction of OxyContin by Purdue Pharmaceuticals in 1996 was a pivotal moment in this narrative. Marketed as a potent yet supposedly less addictive painkiller, OxyContin was promoted with aggressive advocacy and received swift FDA approval, fundamentally altering how potent drugs were prescribed for chronic, non-cancerous pain conditions. This period saw a quadrupling of opioid prescriptions in the U.S., driven by large-scale production, aggressive marketing, and the pharmaceutical industry's reassurances about safety.<sup>5</sup> Consequently, widespread misuse and addiction emerged across demographics, significantly affecting families and individuals of all ages.

As prescription opioids became the gateway to addiction, a second wave of the crisis emerged in the 2010s, characterized by a dramatic shift toward the use of heroin. Individuals addicted to prescription opioids sought heroin as a more accessible and often cheaper alternative, leading to a significant expansion of the heroin market. The crisis further deepened with the onset of the third wave around 2013, marked by an alarming increase in fatalities linked to synthetic opioids, particularly fentanyl. This wave was distinguished by the widespread availability of inexpensive and purer illicit heroin, the influx of highly potent fentanyl and its analogs, and the transition of prescription opioid misusers to heroin and fentanyl. Fentanyl, which is approximately 100 times more potent than morphine, has become the leading driver of overdose deaths in the United States, with synthetic opioids now accounting for the majority of opioid-related fatalities.<sup>6</sup> Each wave,

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<sup>5</sup> Chenaf, "Prescription Opioid Analgesic Use in France," 125.

<sup>6</sup> "Overdose Death Rates Involving Opioids, by Type, United States, 1999–2020," *U.S. Centers for Disease Control and Prevention*, accessed September 27, 2023, <https://archive.cdc.gov/#/details?url=https://www.cdc.gov/drugoverdose/data/OD-death-data.html>.

building upon the last, has compounded accessibility, addiction, and fatality rates, culminating in the multifaceted opioid crisis witnessed today.

## **Theoretical Approach**

This article draws on two complementary theoretical frameworks to examine the divergent responses of France and the United States to the opioid crisis. First, it employs Michel Foucault's concept of biopolitics and discourse analysis to examine how each state constructs and governs the problem of drug addiction.<sup>7</sup> Foucault's insights into how institutions exercise power over bodies, populations, and medical knowledge illuminate why addiction has been framed so differently in these two societies—as a criminal and moral failing in the United States, and as a public health concern warranting compassionate intervention in France. The language used to describe addiction, the institutions empowered to manage it, and the policies enacted to contain it are all expressions of broader power and knowledge structures that this article seeks to unpack. Second, this article employs comparative policy analysis as its methodological framework. By systematically examining government policies, healthcare system structures, and harm reduction strategies within both national contexts, this study identifies causal relationships between specific policy choices and measurable health outcomes, such as mortality rates and treatment access. This direct comparative analysis proceeds across four dimensions: historical regulatory trajectories, the intersection of pain and politics, healthcare system contrasts, and stigma. The comparison is not merely descriptive; it is analytical and normative, asking what the United States can practically learn from France's experience.

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<sup>7</sup> Michel Foucault, *Discipline and Punish: The Birth of the Prison*, trans. Alan Sheridan (Vintage Books, 1977); Henri Bergeron and Pierre Kopp, "Policy Paradigms, Ideas, and Interests: The Case of the French Public Health Policy toward Drug Abuse," *The Annals of the American Academy of Political and Social Science* 582, no.1 (2002): 40.

## **Opioids: A Long-Term American Residency**

The history of opioid usage in the United States reveals a long and intricate relationship with these powerful drugs, dating back to the mid-nineteenth century. Before the U.S. Civil War, opioids were already commonly used for pain management, but it was during this tumultuous period that the first documented opioid addiction epidemic emerged. American army doctors discovered that opioids offered the quickest and most effective relief for the overwhelming number of wounded soldiers they were tasked with treating. Opioid medications, including opium pills, morphine injections, and laudanum (a combination of opium and alcohol), were prescribed for a wide range of ailments, from amputations and gunshot wounds to the suppression of diarrhea and coughing.<sup>8</sup> A Confederate medical manual of military surgery even described opioids as “the one indispensable drug on the battlefield—important to the surgeon, as gunpowder to the ordinance officer.”<sup>9</sup> However, the highly addictive nature of opioids soon became evident to both doctors and the general public. A *Scientific American* article from 1849 described addicted individuals as “willing to sacrifice everything for the fleeting pleasure opioids provided.”<sup>10</sup>

Following the Civil War, many veterans who had been prescribed opioids during their service continued to use the drugs for a variety of health conditions, even turning to them as a remedy for emotional trauma and fatigue.<sup>11</sup> Illicit opioid distribution networks began to emerge, taking advantage of the unregulated international shipments of opium, and further fueling addiction among American citizens. After the war, the addiction rate increased from 1 person per 1,000 Americans in

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<sup>8</sup> David T. Courtwright, *Dark Paradise: A History of Opiate Addiction in America* (Harvard University Press, 2001), 12.

<sup>9</sup> Surgeon-General’s Office of the Confederate States of America, *A Manual of Military Surgery. Prepared for the Use of the Confederate States Army* (Ayres & Wade, 1863), 101, <http://resource.nlm.nih.gov/0257706>.

<sup>10</sup> “Effects of Opium,” *Scientific American* 4, no. 47 (1849): 371.

<sup>11</sup> Courtwright, *Dark Paradise*, 22.

1842 to an alarming 5 per 1,000 people by 1900, marking the nation's first opioid addiction epidemic.<sup>12</sup>

Throughout the twentieth century, studies continued to highlight the inadequate treatment of pain and non-chronic medical issues with the subsequent rise in opioid use.<sup>13</sup> The establishment of the Pure Food and Drug Act in 1906 required drug manufacturers to disclose product contents to consumers. In 1909, the Opium Exclusion Act banned the import of opium for smoking. The 1912 Hague International Opium Convention led to the Harrison Act of 1914, which taxed and regulated the sale and distribution of opium and cocaine-based products, setting the foundation for U.S. drug laws in the twentieth century. The United Nations Single Convention on Narcotic Drugs in 1961 and the Controlled Substances Act (CSA) of 1970 further solidified federal drug policy. The Drug Enforcement Administration (DEA), the enforcement arm of the CSA, oversaw physicians, production quotas, custody chains, and other regulatory aspects.<sup>14</sup> However, despite these federal measures, the United States would face an opioid epidemic in the twentieth century on a scale not seen before, one that underscores the complex and enduring challenges associated with the opioid epidemic in the United States.

## **The Modern-Day American Opioid Crisis: A Flaw in Government Agencies**

The significant escalation in opioid usage that has become a pressing global issue today can be traced back to the latter part of the twentieth century. It is a complex tale intertwined with unsubstantiated claims in pain patient advocacy and the failure of U.S. federal agencies to enforce

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<sup>12</sup> President of the United States, *Combating Drug Addiction and the Opioid Crisis*, 113.

<sup>13</sup> "Timeline of Selected FDA Activities and Significant Events Addressing Substance Use and Overdose Prevention," *U.S. Food and Drug Administration*, accessed April 30, 2026. <https://www.fda.gov/drugs/food-and-drug-administration-overdose-prevention-framework/timeline-selected-fda-activities-and-significant-events-addressing-substance-use-and-overdose>.

<sup>14</sup> President of the United States, *Combating Drug Addiction and the Opioid Crisis*, 114.

public health policies, specifically the 1938 Food Drug and Cosmetic Act (FDCA), a set of laws that authorizes the Food and Drug Administration (FDA) to oversee regulation of the production, sale, and distribution of food, drugs, medical devices, and cosmetics.<sup>15</sup> The FDCA mandates drug manufacturers to submit evidence of a drug being safe and effective before it is marketed to the general public. To be considered safe, a drug's benefits for specific conditions must outweigh potential risks, and efficacy can be demonstrated through at least two "adequate and well-controlled studies."<sup>16</sup> Furthermore, safety and risk indications must be accurately listed on the FDA-approved label.

As physical pain continued to rank among the most commonly reported complaints in America, various studies aimed at finding solutions were published. Regrettably, some of these studies promoted the use of opioids for general pain management. In 1980, a pivotal article published in *The New England Journal of Medicine* carried the headline "Addiction Rare in Patients Treated with Narcotics." This claim was based on an examination of hospital records among patients treated with opioids, although it omitted critical details such as dosage, duration of use, and long-term follow-ups.<sup>17</sup> Another study in 1986 concluded that "opioid maintenance therapy can be a safe, salutary, and more humane alternative" for patients with non-malignant pain and no history of drug abuse.<sup>18</sup> Even though these reports overlooked historical evidence, the claims were accepted by federal agencies and other oversight bodies.

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<sup>15</sup> Clinton Lam and Preeti Patel, "Food, Drug, and Cosmetic Act," in *StatPearls*, July 31, 2023, <http://www.ncbi.nlm.nih.gov/books/NBK585046/>.

<sup>16</sup> Andrew Kolodny, "How FDA Failures Contributed to the Opioid Crisis," *AMA Journal of Ethics* 22, no. 8 (2020): 745.

<sup>17</sup> Jane Porter and Hershel Jick, "Addiction Rare in Patients Treated with Narcotics," *New England Journal of Medicine* 302, no. 2 (1980): 123.

<sup>18</sup> Russell K. Portenoy and Kathleen M. Foley, "Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases," *Pain* 25, no. 2 (1986): 179.

In 1995, Dr. James Campbell addressed the American Pain Society, advocating for healthcare providers to treat “pain as the fifth vital sign” (P5VS).<sup>19</sup> This new perspective on pain emphasized its role in assessing a patient’s condition and led to the use of opioids for both acute and cancer-related pain.<sup>20</sup> Following the public embrace of the P5VS concept, Purdue Pharmaceuticals introduced OxyContin, a synthetic oxycodone-based drug marketed as a powerful pain reliever that was less addictive and more effective than existing brands, including their own MS Contin.<sup>21</sup> At the time, Purdue Pharmaceuticals submitted one adequate and well-controlled study under the FDCA, a two-week clinical trial in osteoarthritis patients.<sup>22</sup> Due to the success and low addiction rates of MS Contin, along with the pressure from the P5VS advocacy among the medical community, OxyContin received swift FDA approval. Despite the FDCA mandate for the FDA to regulate product labeling and claims through at least two clinical trials, the failure to enforce such policies allowed Purdue Pharmaceuticals to manipulate its way into a vast treatment market. The initially approved label for OxyContin in 1995 stated “for the management of moderate to severe pain where the use of an opioid analgesic is appropriate for more than a few days.”<sup>23</sup> This broad description, combined with the belief in its low addiction rates, led the FDA to approve OxyContin off-label. The FDA’s off-label approval enabled Purdue Pharmaceuticals to launch a multifaceted marketing campaign. Between the years 1996 and 2002, Purdue funded the Joint Commission on the Accreditation of Hospitals (JCAHO) to hold over 20,000 seminars and educational programs involving the management of pain.<sup>24</sup> OxyContin became the most frequently prescribed brand-name narcotic

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<sup>19</sup> Vital signs measure the basic functions of the body. The four standard vital signs are: body temperature, blood pressure, pulse, and respiratory (breathing) rate. Informed by Scher, Meador, Cleave, and Reid, “Moving Beyond Pain as the Fifth Vital Sign,” 125.

<sup>20</sup> Scher, Meador, Cleave, and Reid, “Moving Beyond Pain as the Fifth Vital Sign,” 125.

<sup>21</sup> Shivakalyani Adepur and Seeram Ramakrishna, “Controlled Drug Delivery Systems: Current Status and Future Directions,” *Molecules* 26, no. 19 (2021): 39.

<sup>22</sup> Kolodny, “How FDA Failures Contributed to the Opioid Crisis,” 745.

<sup>23</sup> U.S. Government Accountability Office, *Prescription Drugs: OxyContin Abuse and Diversion and Efforts to Address the Problem*, GAO-04-110 (2003), 1, <https://www.gao.gov/assets/gao-04-110.pdf>

<sup>24</sup> U.S. Government Accountability Office, *Prescription Drugs*, 23.

medication for moderate-to-severe pain in the United States, generating annual sales exceeding \$1 billion.<sup>25</sup>

However, in 2000, reports revealed that OxyContin was being abused, leading to a significant rise in overdose mortality rates.<sup>26</sup> A congressional hearing in December 2001 highlighted the need for reform in the marketing and labeling of prescription drugs. In response, the FDA revised OxyContin's label in 2001, adding subsections regarding "Misuse, Abuse, and Diversion of Opioids" and placing a black box warning on the drug.<sup>27</sup> The FDA also issued warnings to Purdue Pharma for potentially false or misleading journal advertisements and promoting uses beyond those that had been proven safe and effective.<sup>28</sup> While the FDA eventually took action, the period of inadequate oversight allowed Purdue Pharmaceuticals and other opioid manufacturers to introduce their highly addictive drugs into the bloodstream of millions of Americans. Between 1997 and 2002, opioid prescriptions in the United States increased tenfold. Unsubstantiated claims, inadequate regulatory oversight, and the aggressive marketing of opioid medications, epitomized by OxyContin, led to a significant increase in prescription rates and, subsequently, widespread addiction and overdose rates.<sup>29</sup>

## **Healthcare Systems: Reimbursement at What Cost?**

The United States healthcare system has long grappled with a complex web of challenges, chief among them being the escalating private costs associated with health services and medications.<sup>30</sup> In 2018, 68 percent of the population was covered by private insurance, while 34.1 percent relied on

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<sup>25</sup> U.S. Government Accountability Office, *Prescription Drugs*, 2.

<sup>26</sup> U.S. Government Accountability Office, *Prescription Drugs*, 2.

<sup>27</sup> U.S. Government Accountability Office, *Prescription Drugs*, 3.

<sup>28</sup> *U.S. Food and Drug Administration*, "Timeline of Selected FDA Activities," 1.

<sup>29</sup> President of the United States, *The President's Commission on Combating Drug Addiction*, 20.

<sup>30</sup> Michael Schatman, Timothy Atkinson, and Jeffrey Fudin, "The Damage Done by the War on Opioids: The Pendulum Has Swung Too Far," *Journal of Pain Research* 98, no. 20 (2014): 265.

public insurance like Medicare, Medicaid, or veterans' programs, and 8 percent went uninsured. This fragmented landscape is further compounded by more than 1,300 distinct payers in the U.S. health insurance market, each with its own procedures, pricing structures, and ways of engaging with healthcare providers. As a consequence, the rates of opioid prescribing and access to opioid use disorder (OUD) treatment options vary significantly, sometimes resulting in disparities along lines of age, location, or socioeconomic class.

Two pivotal bodies in the healthcare landscape, the Centers for Medicare and Medicaid Services (CMS) and JCAHO, play a significant role in ensuring compliance with federal standards and promoting quality and safety in healthcare institutions. In the early 2000s, JCAHO advanced the concept of pain as the "fifth vital sign," and until 2018, the CMS required patient feedback on pain management as a critical factor in determining hospital reimbursement.<sup>31</sup> Pain management feedback requirement incentivized hospitals to resort to opiates so that they scored higher in the pain management factor of reimbursement. Under current policy, the CMS maintains a formulary of medications eligible for federal reimbursement, where 74 percent of opioid painkillers are placed in Tier 1, the lowest cost category eligible for reimbursement.<sup>32</sup> The CMS provides a bundled payment for all "surgical supplies," including hospital-administered drugs for post-surgical pain management. Whereas prescribing post-surgical opioids costs very little, especially if the written prescription is generic, hospitals purchasing non-opioid medication face increased expenses that are not covered by reimbursement.<sup>33</sup> In the United States, 94 percent of hospitals rely on Medicare and Medicaid to

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<sup>31</sup> Olena Mazurenko, Barbara T. Andraka-Christou, Matthew J. Bair, Areeba Y. Kara, and Christopher A. Harle, "Clinical Perspectives on Hospitals' Role in the Opioid Epidemic," in *BMC Health Services Research* 20, no. 1 (2020): 521.

<sup>32</sup> Dora H. Lin et al., "Prescription Drug Coverage for Treatment of Low Back Pain Among US Medicaid, Medicare Advantage, and Commercial Insurers," *JAMA Network Open* 1, no. 2 (2018): 8.

<sup>33</sup> President of the United States, *The President's Commission on Combating Drug Addiction*, 20.

fund 50 percent of their inpatient days.<sup>34</sup> Inadequate reimbursement may hinder clinical providers from utilizing non-opioid treatments, leading to a higher distribution of opioids as a pain treatment for patients, and consequently, Medicaid beneficiaries have a higher rate of OUD from both prescription opioids and their illegal counterparts.<sup>35</sup>

To address the high addiction rate, existing OUD patients covered under private or public insurance may be offered Medication-Assisted Treatment (MAT), which involves the prescription of medication to decrease the risk of overdose mortality. Currently, three medications are approved by the FDA for use in MAT: methadone, buprenorphine, and naltrexone.<sup>36</sup> Research has shown buprenorphine to be the most effective medication to treat OUD and is considered a critical intervention for reducing opioid-related mortality.<sup>37</sup> However, the Drug Addiction Treatment Act of 2000 (DATA-2000) requires any physician to undergo extensive training and receive a waiver from the DEA to obtain the right to prescribe buprenorphine.<sup>38</sup> As of March 2017, only 4.2 percent of the physician population (37,526) obtained a waiver to prescribe buprenorphine, and most U.S. counties had no physicians with such waivers, depriving 30 million individuals of access to office-based treatment.<sup>39</sup> 90.4 percent of physicians who can provide MAT are located in urban counties, leaving individuals residing in rural locations with a higher rate of overdose and other adverse outcomes.<sup>40</sup> The intricate dynamics of the United States healthcare system—from the fragmentation of healthcare

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<sup>34</sup> American Hospital Association, *Fact Sheet: Majority of Hospital Payments Dependent on Medicare or Medicaid*, last updated March 26, 2026,

<https://www.aha.org/fact-sheets/2022-05-25-fact-sheet-majority-hospital-payments-dependent-medicare-or-medicaid>

<sup>35</sup> Medicaid and CHIP Payment and Access Commission, “Medicaid and the Opioid Epidemic,” *Report to Congress on Medicaid and CHIP* (2017), 64,

<https://www.macpac.gov/wp-content/uploads/2017/06/Medicaid-and-the-Opioid-Epidemic.pdf>.

<sup>36</sup> Medicaid and CHIP Payment and Access Commission, “Medicaid and the Opioid Epidemic,” 71.

<sup>37</sup> Abhimanyu Sud, Kellia Chiu, Joseph Friedman, and Julie Dupouy, “Buprenorphine Deregulation as an Opioid Crisis Policy Response- A Comparative Analysis between France and the United States,” *International Journal of Drug Policy* 120 (2023): 1–4.

<sup>38</sup> Sud, Chiu, Friedman, and Dupouy, “Buprenorphine Deregulation as an Opioid Crisis Response.”

<sup>39</sup> Medicaid and CHIP Payment and Access Commission, “Medicaid and the Opioid Epidemic,” 80.

<sup>40</sup> Roger A. Rosenblatt, C. Holly A. Andrilla, Mary Catlin, and Eric H. Larson, “Geographic and Specialty Distribution of US Physicians Trained to Treat Opioid Use Disorder,” *Annals of Family Medicine* 13, no. 1 (2015): 25, <https://doi.org/10.1370/afm.1735>.

coverage to the influence of reimbursement policies—have collectively contributed to persistent challenges in effectively addressing OUD.

## **The Impact of Stigma on Opioid Use Disorder**

Drug use disorders are the most stigmatized health conditions worldwide.<sup>41</sup> Stigma, in the context of drug use disorders, refers to the negative attitudes, beliefs, and stereotypes that result in individuals being rejected, discriminated against, and excluded from various aspects of society.<sup>42</sup> Those grappling with OUD highlight the immense impact of stigma on their lives, affecting employment, physical and mental health, and their willingness to seek treatment.<sup>43</sup>

Historically, addiction has been perceived as a moral failing, seen as a personal choice to succumb to substance use. In 1971, President Richard Nixon declared the infamous “War on Drugs,” elevating drug abuse as “public enemy number one.” This declaration led to increased federal funding geared toward enforcement, penalties, and harsher incarceration for drug offenders. Such policy shifts prioritized punitive measures over treatment and reinforced the notion that drug use was a voluntary and controllable behavior. Such stigma placed responsibility solely on individuals for the consequences of opioid addiction.<sup>44</sup> Over a 15-year period, less than 5 percent of U.S. mainstream media stories advocated for extending substance use treatment, whereas more than 60 percent discussed law enforcement as a solution to the issue.<sup>45</sup>

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<sup>41</sup> Magdalena Kulesza, “Stigma among Individuals with Substance Use Disorders: Does It Predict Substance Use, and Does It Diminish with Treatment?” *Journal of Addictive Behaviors, Therapy & Rehabilitation* 3, no. 1 (2014): 3.

<sup>42</sup> “Mental Health: New Understanding, New Hope,” *The World Health Report 2001* (World Health Organization, 2001): 16, <https://iris.who.int/handle/10665/42390>.

<sup>43</sup> Kulesza, “Stigma among Individuals with Substance Use Disorders,” 2.

<sup>44</sup> Valerie A. Earnshaw, “Stigma and Substance Use Disorders: A Clinical, Research, and Advocacy Agenda,” *American Psychologist* 75, no. 9 (2020): 4.

<sup>45</sup> Ali Cheetham et al., “The Impact of Stigma on People with Opioid Use Disorder, Opioid Treatment, and Policy,” *Substance Abuse and Rehabilitation* 13 (2022): 4.

The impact of stigma falls disproportionately on rural and low-income populations, who also grapple with pre-existing structural disadvantages. In rural communities, the social fabric is tighter and more visible, meaning that individuals with OUD face intense public scrutiny and shame that may not be as acute in urban settings. This heightened social stigma, combined with geographic isolation and the near-total absence of MAT providers creates a dual barrier of shame and inaccessibility that makes treatment functionally out of reach for many.<sup>46</sup> Low-income individuals face further compounding challenges: they are more likely to rely on Medicaid, which reimburses providers at rates that disincentivize comprehensive addiction treatment, and are less likely to have the transportation, flexible employment, or social support networks needed to navigate a fragmented treatment system. The result is that the populations most affected by the opioid crisis—rural communities devastated by the loss of economic infrastructure, and low-income communities in which opioids are aggressively marketed—are precisely those for whom the system’s stigma-laden barriers are highest.<sup>47</sup>

The misconception of opioid use as a willful choice continues to overshadow the understanding of it as a medical illness despite research showing proof of profound alterations in brain circuitry.<sup>48</sup> There is also a distinct separation in the language surrounding OUD constructed within the healthcare system. Treatment protocols describe urine tests as “clean” or “dirty” (rather than “positive” or “negative”), describe individuals tapering off MAT as going under “detoxification,” and only characterize therapy that does not involve medication as being “drug-free.”<sup>49</sup> Such language can influence public perception of how treatment modalities are viewed. Many believe that recovery

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<sup>46</sup> Rosenblatt et al., “Geographic and Specialty Distribution of US Physicians,” 25; Alexander C. Tsai et al., “Stigma as a Fundamental Hindrance to the United States Opioid Overdose Crisis Response,” *PLOS Medicine* 16, no. 11 (2019): e1002969.

<sup>47</sup> Medicaid and CHIP Payment and Access Commission, “Medicaid and the Opioid Epidemic,” 60.

<sup>48</sup> Yngvild Olsen and Joshua M. Sharfstein, “Confronting the Stigma of Opioid Use Disorder—and Its Treatment,” *JAMA* 311, no. 14 (2014): 1394.

<sup>49</sup> Olsen and Sharfstein, “Confronting the Stigma of Opioid Use Disorder,” 1393.

depends solely on the power to abstain from all opioids and that treating OUD with medication is replacing one addiction with another.<sup>50</sup>

The stigma surrounding OUD also extends to harm reduction initiatives, such as drug consumption rooms (DCRs). DCRs are supervised spaces where individuals can consume drugs in safer conditions, monitored by trained staff to reduce the risks of overdose and disease transmission. Despite evidence showing the effectiveness of these facilities in reducing public consumption and overdose mortality, public support for their legalization remains low.<sup>51</sup> Public lack of support can be attributed to the stigma associated with drug use, with many individuals believing that these facilities facilitate illegal activities and promote drug use.<sup>52</sup> In examining the pervasive impact of stigma on OUD, it becomes evident that deeply ingrained societal perceptions not only shape individual experiences but also infiltrate policy, healthcare systems, and media narratives. Addressing stigma is crucial to garner public support for harm reduction initiatives and creating an environment where individuals with OUD feel empowered to seek help and engage in overdose prevention efforts.

## **From Revolution to Regulation: The Evolution of Opiate Control in France**

From the outset, France's approach to controlling opiates was characterized by stringent pharmaceutical regulations, with the governance of opium and its derivatives rooted in poisonous substance laws established as early as 1680.<sup>53</sup> Following the secularization of healthcare by religious orders after the French Revolution, medical advances and industrialization increased access to pharmaceutical care, and France enacted legislative frameworks to regulate the medical field and

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<sup>50</sup> Olsen and Sharfstein, "Confronting the Stigma of Opioid Use Disorder," 1393.

<sup>51</sup> Dagmar Hedrich and Richard Hartnoll, "Harm Reduction Interventions," in *Textbook of Addiction Treatment: International Perspectives*, edited by Nady el-Guebaly, Giuseppe Carrà, and Marc Galanter (Springer Milan, 2015), 1299.

<sup>52</sup> Cheetham et al., "The Impact of Stigma on People with Opioid Use Disorder," 6.

<sup>53</sup> Howard Padwa, *Social Poison: The Culture and Politics of Opiate Control in Britain and France, 1821–1926* (Johns Hopkins University Press, 2012), 109.

drug distribution. Central to these reforms was the Law of 19 Ventôse An XI and the Law of 21 Germinal of 1803, which conferred upon certified professionals the exclusive rights to practice medicine and dispense drugs.<sup>54</sup> The subsequent Poisonous Substance Law of July 19, 1845, further tightened controls by listing 72 substances, including opium, as government-restricted.<sup>55</sup> These measures mandated pharmacist registration for a government license, wholesale transactions exclusively with registered pharmacists, and printed prescriptions to evade penmanship manipulation. Pharmacists were obliged to maintain poison registers for two decades and submit to constant government inspections under penalty of severe fines and imprisonment for non-compliance.<sup>56</sup>

Despite these comprehensive regulations, the enforcement landscape was marred by the nineteenth century's tumultuous political climate, and the laws were largely ineffective in limiting the everyday availability of opioids. In rural areas, the opium market thrived underground, propelled by unlicensed practitioners and folk healers catering to those outside the reach of traditional medical services. Informal healing in the underground medical market significantly propelled the use of opiates in pain management toward the end of the nineteenth century. In 1855, Parisian hospitals used only 272 grams of morphine and 150,000 grams of opium. However, by 1882, these figures had skyrocketed to 20,230 grams of morphine and a staggering 320,000 grams of opium, highlighting the growing reliance on these powerful substances in medical practice.<sup>57</sup>

By the end of the nineteenth century, France, like its national counterparts, began to see the consequences of opioid abuse. Physicians and the general public became increasingly aware of the addictive nature of these substances, coining terms such as 'morphinomania' to describe the

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<sup>54</sup> Sara E. Black, *Drugging France: Mind-Altering Medicine in the Long Nineteenth Century* (McGill-Queen's University Press, 2022), 30.

<sup>55</sup> Black, *Drugging France*, 35.

<sup>56</sup> Padwa, *Social Poison*, 109.

<sup>57</sup> Black, *Drugging France*, 53.

phenomenon.<sup>58</sup> Reports from this time period describe a rising tide of addiction affecting all social strata, from soldiers returning from war to members of high society seeking relief from physical and psychological ailments. In 1883, one doctor estimated that there were 40,000 morphine addicts in Paris alone, while another estimated 60,000 in 1885.<sup>59</sup> The exponential growth in addictions marked a pivotal shift at the turn of the century, as France embarked on reforms to curb opioid addictions while preserving their medical utility. The legislative response, notably influenced by the International Opium Convention of 1912, led to the Law of July 12, 1916, which reclassified substances like opium, morphine, and cocaine as *stupéfiants* (narcotics) rather than poisons.<sup>60</sup> This updated law specifically addressed the importation, commerce, possession, and use of these substances, including the criminalization of drug use in public.<sup>61</sup> Hence, it marked the beginning of a more stringent regulatory regime in which the distribution and prescription of narcotics were subjected to stricter governmental control.

Throughout the twentieth century, France's narcotic control strategies remained intact, effectively curbing opiate availability. However, in May 1968, drug use and youth intoxication emerged as a high-profile issue amidst widespread civil unrest. In response, Law no. 70-1320 of 31 December 1970 was enacted, further solidifying drug policy for both prevention and criminal justice purposes.<sup>62</sup> The legislative measure criminalized drug use in both private and public settings and banned the glorification of any drug. Sentences for the possession of any drug increased from five to twenty years of imprisonment and up to forty years for repeat offenders.<sup>63</sup>

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<sup>58</sup> Padwa, *Social Poison*, 88.

<sup>59</sup> Padwa, *Social Poison*, 96.

<sup>60</sup> Padwa, *Social Poison*, 52.

<sup>61</sup> Ivana Obradovic, "French Drug Policy," in *European Drug Policies: The Ways of Reform*, edited by Renaud Colson and Henri Bergeron (Routledge, Taylor & Francis Group, 2017), 88.

<sup>62</sup> Law No. 70-1320 on Health Measures to Combat Drug Addiction and the Repression of Trafficking and Illicit Use of Poisonous Substances, Ministry of Justice; Ministry of Public Health and Social Security, adopted 31 December 1970, <https://www.legifrance.gouv.fr/jorf/id/JORFTEXT000000321402>.

<sup>63</sup> Obradovic, "French Drug Policy," 88.

## **Shifting Paradigms: The Evolution of French Stigma Towards Harm Reduction**

In the wake of the transformative events of May 1968, France's drug policy underwent significant changes, influenced by French thinker Michel Foucault's critical insights into mental illness and societal control mechanisms.<sup>64</sup> Foucault influenced how drug addiction was perceived, moving from a psychoanalytical framework to one that prioritized political and social regulation, challenging the stigma on those suffering from OUD and the association of addiction with criminality and moral failing. Despite evidence pointing to the public health dangers inherent to such strict drug policy and treatment approaches, the majority of French treatment providers and policymakers remained strongly opposed to harm-reduction measures, viewing them as a retreat in the campaign against drug use and addiction. However, in the persistence of this stigmatization, evidence pointing to the health dangers of such a strict drug policy arose. In the 1980s, the AIDS epidemic spotlighted France's about-face in addiction treatment policy. Due to the lack of harm-reduction services and the 1970 law provisions that made it difficult for treatment providers to educate safe drug use, the nation grappled with the highest HIV rates in Europe.<sup>65</sup> The pressing health crisis gradually softened resistance, pivoting the perspective on drug use from a criminal issue to a public health concern.<sup>66</sup> By the early 1990s, a diverse coalition of citizens, including medical professionals, NGO workers, and those directly affected by drug policies, began to challenge the French government's stance publicly, advocating for harm reduction strategies over three years.<sup>67</sup> This public outcry, amplified by national and international media, shifted the perception of OUD and drug addiction towards a more harm reduction-oriented approach. By 1993, the narrative began to

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<sup>64</sup> Bergeron and Knopp, "Policy Paradigms, Ideas, and Interests," 40.

<sup>65</sup> Obradovic, "French Drug Policy," 89.

<sup>66</sup> Henri Bergeron and Renaud Colson, "What Lessons from France's Experience Could Be Applied in the United States in Response to the Addiction and Overdose Crisis?" *Addiction* 117, no. 5 (2022): 1191.

<sup>67</sup> Bergeron and Kopp, "Policy Paradigms, Ideas, and Interests," 44.

change under the guidance of Health Minister Simone Veil, who recognized methadone as a tool to curb AIDS spread and aid drug users in seeking help.<sup>68</sup> A pivotal moment came in 1995 when a commission led by Professor Roger Henrion highlighted the detrimental link between the lack of harm reduction and rising HIV rates, denouncing France's past addiction treatment strategies as a "health and social catastrophe."<sup>69</sup>

Reforms in the addiction treatment framework marked a dramatic departure from France's traditionally punitive approach, favoring medical interventions and the expansion of needle and syringe exchange programs, opioid substitution treatments, and safe injection sites. These changes led to a notable decrease in HIV infections and drug overdose deaths.<sup>70</sup> The shift toward harm reduction practices was also apparent in law enforcement, with 1999 Ministry of Justice guidelines favoring health service referrals over incarceration for drug use offenses and decreasing the number and length of sentences for drug use.<sup>71</sup> This approach underscored the growing importance of harm reduction in French drug policy, culminating in the 2004 Law No. 3125-1, which established a comprehensive legal framework for risk reduction activities.<sup>72</sup> The law holds the government responsible for establishing harm reduction policy to prevent the spread of infection, death by drug overdose, and the social and psychological damage caused by narcotics use, including the need for motivation, not just substance abstinence, in the process of detoxification.<sup>73</sup> By 2006, the establishment of the Support Centre for the Reduction of Drug-related Harms (CAARUD) reinforced the government's commitment to harm reduction, offering a range of services aimed at treatment

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<sup>68</sup> Bergeron and Kopp, "Policy Paradigms, Ideas, and Interests," 46.

<sup>69</sup> Roger Henrion, "Rapport de la Commission de Réflexion sur la Drogue et la Toxicomanie" *La Documentation Française* (1995).

<sup>70</sup> Bergeron and Colson, "What Lessons from France's Experience," 1191.

<sup>71</sup> Bergeron and Kopp, "Policy Paradigms, Ideas, and Interests," 39.

<sup>72</sup> France, Ministry of Social Affairs, *Public Health Code*, Art. L3125-1 (2004).

<sup>73</sup> L'Observatoire Français des Drogues et des Toxicomanies (OFDT) "Rapport National 2012 (données 2011) à l'OEDT per la Point Focal Français du Réseau Reitox," *European Monitoring Center for Drugs and Addiction, 2012*: 17. [https://bdoc.ofdt.fr/doc\\_num.php?explnum\\_id=14716](https://bdoc.ofdt.fr/doc_num.php?explnum_id=14716).

access, health, and rehabilitation for drug users.<sup>74</sup> Public opinion on drug policy and harm reduction underwent a significant shift as well, with 72 percent of the French population supporting educational initiatives on safer drug use and the establishment of drug consumption rooms (DCRs), reflecting a more comprehensive and compassionate approach.<sup>75</sup>

The transformative shift in France's approach to drug policy, catalyzed by the critical reflections on societal control mechanisms and the significant events of May 1968, has paved the way for a more humane and effective strategy in combating drug addiction. The AIDS crisis of the 1980s served as a crucial turning point, exposing the dire consequences of punitive policies and the absence of harm reduction services, thereby catalyzing a reevaluation of addiction treatment from a criminal- to a health-centric concern. This paradigm shift, bolstered by public advocacy and legislative reforms, has facilitated the establishment of comprehensive harm reduction measures, including needle and syringe exchange programs, opioid substitution treatments, and the pioneering introduction of DCRs. These initiatives have not only led to a decrease in HIV infections and drug-related deaths but have also fostered a supportive environment that prioritizes the dignity and well-being of individuals battling addiction.

## **Modernizing French Healthcare: Integrating Addiction Treatment**

The multi-modal approach to addiction in France combines the primary care, hospital, and medico-social sectors. The offer is multidisciplinary and includes medicinal treatment through substitution or post-withdrawal MAT, psychiatric and somatic comorbidities treatment, a psychotherapeutic approach, socio-educational care, harm reduction, and family services. As the

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<sup>74</sup> L'Observatoire Français des Drogues et des Toxicomanies (OFDT), 2012 National Report, 17.

<sup>75</sup> French Monitoring Centre for Drugs and Drug Addiction (OFDT), "Drugs: Perceptions of Substances, Public Policies and Users—Tendances 131," April 2019, <https://en.ofdt.fr/en/publication/2019/drugs-perceptions-substances-public-policies-and-users-696>.

multi-modal system is well-rounded, it is made possible through the French healthcare system's comprehensive structure, which has been fundamental to the nation's strategy in addiction treatment.

From the inception of social insurance (SHI) in 1930, mandating employer-provided health coverage for a broad range of life events, to the expansion of the Social Security insurance system for retirees and self-employed in 1945, France has consistently prioritized accessible healthcare.<sup>76</sup> The passing of the Universal Health Coverage Act (CMU) in 2000 was a pivotal moment, ensuring that all citizens, irrespective of their employment status or citizenship, could access government-financed insurance.<sup>77</sup> Following the implementation of CMU, less than one percent of the population was left uninsured.<sup>78</sup> Despite comprehensive coverage from the Ministry of Social Affairs, Health, and Women's Rights (SHI), patients are responsible for certain copayments, which Voluntary Health Insurance (VHI), typically employer-provided or state-sponsored, can help offset.<sup>79</sup> By the year 2000, 86 percent of the population had VHI in addition to SHI.<sup>80</sup>

Access to care is further facilitated by a policy determining the number of medical school admissions, ensuring an ample supply of healthcare professionals. There are around 223,557 general practitioners or specialists in France, a ratio of 3.4 per 1,000 people.<sup>81</sup> General practitioners are paid a fixed amount for office visits regardless of duration or frequency, with general consultations reimbursed at a 65 percent replacement level or 100 percent if the patient is diagnosed with a chronic

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<sup>76</sup> Simone Sandier, Valerie Paris, and Dominique Polton, "Health Care Systems in Transition," ed. Sarah Thomson and Elias Mossialos, *WHO Regional Office for Europe on Behalf of European Observatory on Health Systems and Policies* (2004), 7, <https://www.irdes.fr/EspaceAnglais/Publications/IrdesPublications/HealthCareSystemsInTransition.pdf>.

<sup>77</sup> Sud et al., "Buprenorphine Deregulation," 6.

<sup>78</sup> Roosa Tikkanen et al., "France | International Health Care System Profiles," *The Commonwealth Fund Organization*, June 5, 2020, <https://www.commonwealthfund.org/international-health-policy-center/countries/france>.

<sup>79</sup> The SHI is responsible for setting government policies for public health and financing the healthcare system. The SHI covers hospital care, treatment in public/private rehabilitation centers, outpatient care prescribed by physicians, maternity care, prescription drugs, medical appliances, and prescribed transportation/home care. Tikkanen et al., "France | International Health Care System Profiles."

<sup>80</sup> Sandier, *Health Care Systems in Transition*, 44.

<sup>81</sup> Tikkanen et al., "France | International Health Care System Profiles."

illness.<sup>82</sup> Additionally, all hospitals are reimbursed under SHI via the diagnosis-related group (DRG) system, which applies to all inpatient and outpatient admissions and covers all medical services and physicians' salaries.<sup>83</sup>

French reimbursement policies have facilitated treatments established in the multi-modal addiction treatment model, including Medication-Assisted Treatment (MAT), psychosocial support services, and substance abuse treatment centers, to be fully covered under Social Security.<sup>84</sup> Previously, methadone was offered as a treatment for OUD, but only 20–30 percent of patients who needed MAT could access it. However, in 1996, Buprenorphine was introduced into the French market, and Buprenorphine Maintenance Treatment (BMT) was established as the official treatment for OUD. In contrast to the United States' restrictive waiver system, French physicians are not required to take any type of training to prescribe buprenorphine, and any pharmacy can provide the medication. With 26 percent of French physicians prescribing buprenorphine to 75 percent of overall patients in MAT, BMT has been associated with consistent benefits surrounding OUD. In the five years following the introduction of buprenorphine, the number of individuals with OUD receiving MAT increased by 95 percent, and the number of overall overdose deaths declined by 79 percent.<sup>85</sup>

## **The Intersection of Pain Management, Policy, and Opioids in France**

As global attention increasingly turned towards pain treatment and management, French doctors and researchers positioned themselves prominently, dividing into two informal subspecialties. The first, composed mainly of anesthesiologists and neurosurgeons affiliated with public research

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<sup>82</sup> Melina Fatseas, Jacques Dubernet, Jean-Pierre Daoulouède, and Marc Auriacombe, "Buprenorphine in the Treatment of Opioid Addiction: The French Experience," in *Textbook of Addiction Treatment: International Perspectives*, 501–10 (2015): 503.

<sup>83</sup> Tikkanen et al., "France | International Health Care System Profiles."

<sup>84</sup> Fatseas et al., "Buprenorphine in the Treatment of Opioid Addiction," 503.

<sup>85</sup> Fatseas et al., "Buprenorphine in the Treatment of Opioid Addiction," 504.

institutes, dedicated themselves to identifying the causes of chronic pain. The second group, including neurologists and general practitioners, viewed chronic pain through a social-psychological lens, focusing on treatments that integrated psychological and physiological interventions due to the complexity and often intractable nature of chronic pain.<sup>86</sup> With pain management not recognized as a formal specialty within the French medical system, these groups converged on promoting a multi-modal pain clinic model. This innovative approach combined physical, social, and psychological strategies to bolster the field of pain specialists and establish standardized pain centers nationwide.

The release of the WHO's three-step analgesic ladder in 1986 recommended a progression from non-opioid treatments to strong opioids for chronic pain management.<sup>87</sup> By the 1990s, WHO advocacy had deeply woven pain treatment into French policy's fabric. Notably, in 1993, Paris hosted the largest global congress of the International Association for the Study of Pain, and by 1994, French lawmakers had identified pain management as a health policy priority.<sup>88</sup> In 1994, the first report on pain in France, led by Senator Lucien Neuwirth, framed the country's pain problem as a human rights issue. The drive to improve opioid access led to negotiations with pharmaceutical giants, including MundiPharma, Purdue Pharma's global arm, to equip the nation with opioid distribution systems. The high pharmaceutical funding facilitated the establishment of multi-modal pain clinics nationwide.

In March 2002, Law no. 1110-5, Kouchner's Patients' Rights Act, stated that everyone has the right to receive care to relieve their pain, and health professionals must use all the means at their disposal to ensure everyone a dignified life until death.<sup>89</sup> However, the influence of pharmaceutical

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<sup>86</sup> Pryma, "Technologies of Expertise," 36.

<sup>87</sup> Pryma, "Technologies of Expertise," 36.

<sup>88</sup> Pryma, "Technologies of Expertise," 39.

<sup>89</sup> France, Ministry of Social Affairs, *Public Health Code*, Art. L110-5 (2002).

companies was evident in the creation of pain scales that subtly encouraged higher opioid prescription rates. A critical open letter from a leading pain specialist in 2004 highlighted the over-prescription of opioids and the problematic ties between the government, the medical community, and pharmaceutical industry, criticizing the pain advocacy initiative as 95 percent financed by commercial pharmaceutical companies.<sup>90</sup> The new insights led French pain specialists to change their approach, moving away from supporting opioids and returning to their initial emphasis on multi-modal clinics. While lobbying has played a role in the expansion of multi-modal pain centers, the refocus on multi-modal pain clinics helped prevent opioids from taking over the field. By 2017, France had established 254 multidisciplinary pain centers.<sup>91</sup>

## **Comparative Insights on Opioid Crisis Management**

The historical evolution of opioid control in France and the United States offers a revealing lens through which to view their respective strategies towards managing opioid misuse. Both countries have deep-rooted histories with these substances, yet their paths diverge significantly due to differences in regulatory approaches, societal attitudes, and healthcare system structures.

In the United States, the presence of opioids dates back to the mid-19th century, with usage intensifying during the Civil War, leading to the country's first opioid epidemic. Initial regulatory measures, such as the Pure Food and Drug Act of 1906 and the Harrison Narcotics Tax Act of 1914, sought to curb the burgeoning crisis by mandating the labeling of drug contents and regulating narcotics through taxation and registration, respectively. Despite these efforts, the twentieth century witnessed fluctuating challenges related to opioid use, culminating in stringent controls under the

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<sup>90</sup> Pryma, "Technologies of Expertise," 39.

<sup>91</sup> Pryma, "Technologies of Expertise," 41.

Controlled Substances Act of 1970.<sup>92</sup> However, these measures were often reactive, responding to crises rather than preempting them.

Conversely, France's regulatory journey began earlier, rooted in the post-Revolution era with the Poisonous Substance Law of 1845, setting a precedent for strict control over narcotics. Early intervention, coupled with subsequent laws like the 1916 legislation reclassifying opiates as narcotics, underscored consistent governmental resolve to regulate opioid distribution and consumption. Unlike the U.S., France's approach was characterized by an enduring commitment to tight regulation, even in the face of socio-political upheavals, such as the civil unrest in May 1968, which led to the Law of 31 December 1970 that further solidified the nation's stringent drug policies.<sup>93</sup>

The distinct trajectories of these nations reveal the impact of early regulatory frameworks and societal engagement with the opioid issue. France's early and consistent regulation likely contributed to a more contained opioid misuse scenario, limiting the scale of its modern-day crisis compared to the United States. The U.S. experience, marked by later regulatory responses and significant pharmaceutical lobbying, has faced a more pronounced challenge in curbing opioid misuse and addiction.

## **The Intersection of Pain and Politics**

The opioid crisis in both the United States and France illuminates the profound impact of pharmaceutical lobbying, political advocacy, and government regulation on public health outcomes. In the United States, the narrative is deeply colored by Purdue Pharma's introduction of OxyContin into the market—a maneuver made possible by exploiting the regulatory framework established by

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<sup>92</sup> President of the United States, *The President's Commission on Combating Drug Addiction*, 114.

<sup>93</sup> France, Ministry of Justice and Ministry of Public Health and Social Security, *Law No. 70-1320* (1970).

the FDCA and insufficient enforcement by the FDA. The company's aggressive marketing, supported by unsubstantiated claims of safety and effectiveness, underscores a broader issue of regulatory oversight failure. This lapse significantly contributed to the opioid epidemic, revealing a disconcerting intersection where pharmaceutical interests overrode public health safeguards. Conversely, France embarked on its journey against opioid misuse with a robust regulatory apparatus, historically vigilant over pharmaceutical practices. However, as France aimed to modernize its pain management protocols, aligning more closely with international standards, it inadvertently became more susceptible to the influences that had plagued the U.S. MundiPharma, representing Purdue Pharma's interests abroad, spearheaded lobbying efforts to relax France's stringent opioid controls. The subtle erosion of these regulatory barriers highlights the insidious nature of pharmaceutical lobbying, capable of penetrating even the most guarded health policy environments.

Both nations' narratives underscore a critical observation: regardless of the initial regulatory stance, the pharmaceutical industry's influence can significantly sway health policies and patient safety protocols. In the United States, Purdue Pharma's machinations with OxyContin, facilitated by an accommodating FDA, paved the way for a crisis characterized by overprescription and widespread misuse. In France, the gradual shift towards leniency in opioid prescribing, influenced by international comparisons and industry lobbying, reveals the nuanced challenges of maintaining stringent pharmaceutical controls. The path forward demands a concerted effort to reinforce regulatory frameworks, enhance transparency in drug approval processes, and champion ethical practices in pain management.

## **Contrasting Approaches to Opioid Addiction Treatment**

The healthcare systems of France and the United States offer contrasting frameworks in addressing opioid addiction, reflecting broader philosophical differences in healthcare provision and accessibility. France's universal healthcare coverage, underpinned by the CMU of 2000, ensures that nearly all citizens are insured, leaving less than one percent uninsured.<sup>94</sup> This extensive coverage supports a holistic and accessible approach to opioid addiction treatment, including MAT and multi-modal therapy approaches. The French system's strength lies in its cohesive structure, providing comprehensive care without the significant disparities seen in the U.S. healthcare model. In contrast, the United States grapples with a fragmented insurance landscape, where 68 percent of the population relies on private insurance and 34.1 percent on public insurance programs such as Medicare and Medicaid, leaving 8 percent without coverage.<sup>95</sup> This disjointed system, characterized by more than 1,300 distinct payers, creates variances in opioid prescribing rates and access to OUD treatments, exacerbating inequalities in healthcare access. The U.S. approach, influenced by the reimbursement policies of federal bodies like the CMS and accreditation organizations like JCAHO, often inadvertently incentivizes opioid prescribing through economic considerations, particularly in post-surgical pain management.

France's proactive stance on opioid treatment is exemplified by the implementation of BMT in 1996, which did not require physicians to undergo specialized training to prescribe buprenorphine. This approach markedly increased access to MAT, leading to a 95 percent surge in individuals receiving treatment and a 79 percent decrease in overdose deaths, showcasing the effectiveness of France's healthcare system in addressing opioid dependency.<sup>96</sup> Conversely, the U.S. introduced DATA-2000, requiring physicians to obtain an "X waiver" to prescribe buprenorphine for OUD—a barrier that has significantly limited access to effective treatment options. By March 2017, only 4.2

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<sup>94</sup> Sandier, *Health Care Systems in Transition*, 7.

<sup>95</sup> Medicaid and CHIP Payment and Access Commission, "Medicaid and the Opioid Epidemic," 60.

<sup>96</sup> Fatseas et al., "Buprenorphine in the Treatment of Opioid Addiction," 504.

percent of U.S. physicians had obtained this waiver, underscoring a critical access issue, especially in rural areas.<sup>97</sup>

The French model also benefits from a policy that incentivizes physicians to practice in underserved areas, ensuring a more equitable distribution of healthcare resources across the country. This method contrasts with the U.S., where a significant portion of MAT-authorized physicians are located in urban counties, leaving rural populations disproportionately affected by opioid addiction without adequate access to care. Adopting elements of France's model, particularly in enhancing access to MAT and ensuring equitable healthcare distribution, could significantly benefit the U.S. in its ongoing battle against the opioid crisis.

## **Stigma and Societal Perceptions Compared**

The discourse on stigma and societal perceptions surrounding OUD reveals profound contrasts between France and the United States, as each country's narrative reflects its unique societal and policy stance towards drug addiction. France's transformative journey from historically associated stigma with OUD to the adoption of robust harm reduction policies starkly contrasts with the enduring stigma and punitive approaches prevalent in the U.S.

In France, the significant events of May 1968 and the subsequent AIDS crisis in the 1980s catalyzed a societal shift toward a more empathetic and public health-oriented perspective on drug addiction. The implementation of harm reduction measures, including needle and syringe exchange programs and drug consumption rooms, represented a significant departure from previous punitive stances. This evolution was propelled by public advocacy and a change in societal attitudes, leading to a decrease in HIV infections and drug overdose deaths. The legal framework, solidified by the

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<sup>97</sup> Medicaid and CHIP Payment and Access Commission, "Medicaid and the Opioid Epidemic," 80.

2004 Law No. 3125-1, not only institutionalized harm reduction efforts but also reflected widespread societal endorsement of these strategies.<sup>98</sup> Influenced by Michel Foucault's philosophical insights and the realities of the AIDS epidemic, France's approach evolved to view OUD through a lens of empathy and public health rather than criminality and moral failing.

Conversely, in the United States, the stigma intertwining drug use with moral failing and criminal behavior has significantly shaped the approach to OUD. The "War on Drugs" initiated in the 1970s emblematically entrenched punitive responses to drug addiction, amplifying stigma and favoring incarceration over treatment. Despite growing evidence supporting harm reduction strategies and recognizing OUD as a medical condition, stigma persists within federal policies, healthcare systems, and societal attitudes, deeply impacting individuals' willingness to seek treatment. The U.S. reluctance to fully embrace harm reduction, as evidenced by debates surrounding DCRs and misconceptions about MAT, highlights the challenges posed by entrenched stigma. France's adoption of harm reduction policies has led to public health successes, such as a notable reduction in HIV rates among drug users. Meanwhile, the U.S. continues to struggle with reducing HIV rates and overdose deaths, hindered by persistent stigma and limited adoption of harm reduction measures.

The discourse on stigma and societal perceptions surrounding OUD in France and the United States highlights the fundamental role of public health philosophy in informing drug policy and treatment strategies. France's progression towards an empathetic, health-centric model offers critical lessons for the U.S., and underscores the imperative for a societal shift toward understanding and compassion. Recognizing OUD as a medical condition and adopting inclusive, evidence-based treatments can significantly dismantle the stigma barriers, and facilitate comprehensive care and support for individuals on the path to recovery.

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<sup>98</sup> France, Ministry of Social Affairs, *Public Health Code*, Art. L3125-1 (2004).

## **Conclusion**

France's evolution from stringent regulation to modernized healthcare and harm reduction policies underscores the necessity of a multifaceted strategy in addressing complex public health issues. By acknowledging the limitations of punitive measures and embracing a patient-centric approach, France has made significant strides in reducing opioid misuse and its associated harms. France's progression towards an empathetic, health-centric model offers critical lessons for the U.S.

From the experiences of France and the U.S., it becomes evident that effective opioid crisis management requires a harmonious blend of vigilant government oversight, transparent clinical research, and an ethical framework that places patient safety above pharmaceutical profits. The intersection of pain management and policy in both countries illuminates the balance required to navigate the complexities of public health in the face of political and economic pressures. Effectively tackling the opioid epidemic necessitates a synergistic approach that combines proactive regulatory measures, ethical pharmaceutical practices, and compassionate societal attitudes. The U.S. has much to learn from France's example to overhaul a healthcare system that puts public health and justice at the forefront, thus providing hope and healing to millions impacted by opioid addiction. The urgency of this crisis demands bold, immediate action to avert further loss of life and societal damage. This article serves as a call to action for policymakers, healthcare providers, and communities to champion a robust, ethical, and patient-centered approach in managing the opioid crisis, which is vital in securing the well-being of future generations.

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