US hospital visits due to opioid issues top one million a year

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A report issued Tuesday by the Agency for Healthcare Research and Quality (AHRQ) shows that there were 1.27 million emergency room visits or inpatient stays for opioid-related issues in 2014, the latest year for which there is sufficient data. This represents a 64 percent increase for inpatient care and a 99 percent hike in emergency room treatment compared to figures from 2005.

Aside from the overall skyrocketing of hospital visits, the report found that the previous discrepancy between males and females in the rate of opioid-related inpatient stays in 2005 has disappeared. The rate of female hospital visits has now caught up to that of males.

Another significant finding is that from 2005 to 2014, the age groups with the highest rate of opioid-related inpatient stays nationally were 25–44 and 45–64 years—in other words, adults in their prime working years, not adolescents. The highest rate of opioid-related Emergency Department (ED) visits was among those aged 25–44 years.

This mirrors another recent report, which found that death rates have risen among the same age group, 25–44, in every racial and ethnic group and almost all states since 2010, likely driven in part by the opioid epidemic.

Using a patient's area code to estimate the income range of people affected, the researchers were also able to report on differences between the rich and the poor. The results showed that rates of hospital admission or emergency room visits were higher in poorer neighborhoods, but that the increases were uniform, between 75 percent and 85 percent over the 10-year period, across all income ranges.

At the top of the national list for inpatient opioid care is Maryland, which recorded nearly 404 admissions per 100,000 residents. The state, which has been rocked by the epidemic in recent years largely due to the spread of the synthetic opioid fentanyl, has seen a quadrupling of opioid-related deaths since 2010. Baltimore City alone saw 694 deaths from drug and alcohol-related overdoses in 2016—nearly two a day.

Following Maryland, the top 10 states with the highest rate of opioid-related hospital admissions in 2014 were Massachusetts, Rhode Island, New York, West Virginia, Connecticut, Washington, Oregon, Illinois and Maine.

There was substantial state-to-state variation in the findings. States such as Texas, Nebraska and Iowa, for example, are reporting substantially lower rates of hospital admissions than others, which coincides with the unevenness between states in the number of overdose deaths in 2016.

This unevenness may reflect, in part, the ways in which the more potent opioid, fentanyl, has spread throughout the country. The historical divide in the nation's heroin market between powdered heroin in the East and black tar heroin from Mexico in the West means that fentanyl has been somewhat restricted to certain areas, particularly in the Appalachian and Northeast region.

This does not mean that the opioid epidemic is less severe in the areas with lower hospital visits and deaths rates, only perhaps less deadly. If drug production and distribution makes a shift in the West from black tar to powdered heroin, there will likely be a rise in the use of fentanyl along with it, and consequently the death toll would rise to East Coast levels.

Additionally, the lower rate of hospital visits in rural areas is often due to a lack of access to medical care. Rural areas have even fewer resources to deal with the drug epidemic than their urban neighbors.

Katherine, who works for a nonprofit effort in rural

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Michigan relating to substance abuse, spoke to WSWS reporters about the unique challenges that face rural areas: "I work in a small rural community with quite a significant opiate crisis just as it is in urban areas. In our county, we don't have any treatment options. We have one clinic that is limited in what they can do, and it is always at capacity. They [addicts] have to go out of county for treatment, which is about 90 miles away, and there is typically a wait list in these places that are all in major cities. Every place is pretty much running at max capacity all the time."

If users decide they need help in a rural town it is very likely they will have to wait 72 hours or more before they can get a bed in a rehab, or in a detox facility. Katherine commented on the further challenges that this poses to addicts seeking recovery help: "Around here, if they [a user] are at a point when they are ready—which is a big step and where they often feel very vulnerable—they are basically told to continue using at their regular dosage until something opens up. ... To be told something like that I think makes them lose hope that there is a way out of addiction."

The obstacles facing workers in the cities are different, but no less severe. Laura, who works in an adult intensive care unit (ICU) in Boston, told the WSWS: "Honestly, one of the hardest things is, even when patients bring themselves in, they have a tendency while detoxing to become verbally or psychologically abusive out of desperation. A detox that ends up in the ICU, which is usually alcoholics because the DTs are life-threatening, is a lot of work. With understaffing in hospitals being what it is, it's kind of a nightmare."

Drug users who voluntarily enter the emergency room are almost always looking for a safe place to detox, an extraordinarily painful and traumatic process. Patients going through withdrawal from opioids experience vomiting, uncontrollable shaking, sweating, cramping, diarrhea, insomnia, anxiety, intense cravings, etc.

Most hospitals do not have options for patients who wish to detox. Some doctors are actually authorized to prescribe patients an additional drug called suboxone to help with the symptoms. However, without support and supervision this treatment option often proves to be a futile and even dangerous one. Reports of suboxone abuse, and even overdoses, have spiked significantly since the onset of the crisis.

Laura explained the limitations that exist even for hospitals that provide resources for detox: "We have a detox unit. But it can't do much for patients who are acutely withdrawing. If they score over a certain number on the scales that we use, they get transferred to the regular hospital units. And we don't have addiction training. … Addicts are a underserved and vulnerable population."

Health care workers in both rural and urban areas express frustration over the seemingly endless crisis. The sheer breadth of the opioid epidemic is astounding. It has bled into nearly every major social challenge of the day, putting a strain not only on hospital and emergency workers, but also on social welfare programs, the education system, mental health facilities, child care workers and more. This creates a situation where the drug epidemic, itself the product of a diseased social order, becomes a major contributor to its further decay.

The capitalist system as a whole is the source of the drug abuse epidemic, as any combination of the various strands of social ills affecting an individual could lead to substance abuse and addiction. The scope of the crisis represents a very complex manifestation of the problems created by a society in which every aspect of life is subjugated to private profit and where only an infinitesimal fraction of the resources available are directed to meet social need.

Katherine in Michigan touched on this reality in her comments to the WSWS: "I think that there are so many people who are suffering, experiencing poverty and extreme hardship, or who are encountering prejudice and oppression, and these factors are all compounding to create the basis for the drug epidemic to flourish. It is such a multifaceted issue. People are feeling extremely helpless watching the events in society and the political situation, and it is almost like a building up of unrest underneath the surface."

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