

1. When Paracelsus (Theophrastus Bombastus von Hohenheim, 1493-1541) stated that he would not like to be a physician without opium, he underlined the importance of opium, which was then widely used as an analgesic, antitussive, hypnotic, sedative and tranquillizer and in the treatment of diarrhoea. The use of opium itself as a universal drug has since become a part of history: opium is no longer used in therapy, but it is used as the starting material for the production of alkaloids, such as morphine and codeine. Today, natural and synthetic opioids are prescribed as analgesics and antitussives and in the treatment of diarrhoea. A great variety of synthetic hypnotics, sedatives and anxiolytics are used to treat insomnia and many different psychiatric disorders. Thus, narcotic drugs and psychotropic substances are as indispensable in the field of medicine today as opium was in the past.

2. When Paracelsus was doing his best to convince his colleagues in Europe of the therapeutic value of opium, the non-medical use of opium (opium smoking) started to create major problems in Asia. The health and social consequences of that development are well known: the lives of millions of individuals were ruined, above all in China.

3. This dual characteristic of opium, as well as of many other narcotic drugs and many psychotropic substances, both natural and synthetic, is at the root of the national and international control systems that have gradually developed since the beginning of the twentieth century, when the international community decided to take action against the tremendous suffering of millions of people as a result of the unrestricted availability of drugs for non-medical purposes.

A. The situation before the evolution of the international drug control system

Opium smoking in China

4. China was forced by the United Kingdom of Great Britain and Ireland and other colonial Powers to abandon its efforts to curtail the trade in opium. The Opium Wars¹ led to the legalization of the import of opium and opened the doors for the free flow of opium from British India into China. Opium smoking spread,

resulting in a drastic increase in opium poppy cultivation and opium production in China. In 1906, 30,000 tonnes of opium were produced in China; in the same year, an additional 3,500 tonnes were imported into the country. Consumption in China alone at the beginning of the twentieth century is therefore estimated to have been more than 3,000 tonnes in morphine equivalent. In comparison, today, worldwide medical consumption of all opiates amounts to approximately 230 tonnes in morphine equivalent annually, while illicit consumption of opiates is estimated to be about 380 tonnes in morphine equivalent annually. These figures demonstrate that the opiate addiction situation today (which mainly involves heroin addiction), although it is serious, is in no way comparable with the addiction epidemic that prevailed when narcotic drugs were available without restriction to medical use.

5. In China, following the gradual elimination of opium production starting in 1907 (whereby production was reduced by 10 per cent per year) and the agreement with the British Government regarding a similar reduction in opium imports, domestic production substantially decreased. In 1914, despite the fact that opium imports from India had been discontinued, large amounts of opium were smuggled into China out of other Asian countries in order to supply the opium addicts in China, who at that time accounted for far more than 10 million² out of a total estimated population of approximately 450 million.

Opium smoking in other Asian countries

6. At the beginning of the twentieth century, opium eating was the predominant method of consumption for both the quasi-medical and the non-medical use of opium in India and in some other Asian countries. However, opium smoking was widespread in south-east Asia (mainly in Burma) and in some parts of India and west Asia (mainly in territories belonging today to Afghanistan, the Islamic Republic of Iran and Pakistan). In some Persian towns, more than 10 per cent of the population were regular opium smokers in 1914.

Non-medical use of opium in Europe

7. In the nineteenth century, in most European countries, prescription obligations and the restriction of dispensing to pharmacies prevented the large-scale non-medical use of opium. One exception was the United Kingdom, where cheap opium was sold in groceries and freely used until 1868, when the first Pharmacy Act became a law.³ Opium smoking appeared also in other European countries that had colonies in Asia, as evidenced by the large increase in the number of *fumeries* (opium dens) following the colonization of Indochina. At the beginning of the twentieth century, there were a large number of opium dens in Paris and in French seaports (Bordeaux, Marseille, Toulon etc.). In 1908, the import of opium was regulated and the opium dens were closed, but there is evidence that some clandestine opium dens continued to exist in Paris until 1916.

Abuse of morphine, heroin and other opiates in China

8. The shift from opium smoking to morphine injection in China started during the last years of the nineteenth century, but the expansion of the new habit to epidemic proportions took place in the twentieth century. Before 1909, an average of 132 tonnes of morphine were exported annually from the United Kingdom to China and, until that year, those exports were considered legal and were exported directly to China without passing through a third country. By contrast, the first estimate of the world's morphine requirements for medical purposes, established by the League of Nations in 1931, was only 10 tonnes, a small fraction of that amount, and today the entire world's annual morphine consumption is about 16 tonnes. Under domestic and international pressure, the British Government introduced a certificate system that obliged manufacturers to request a certificate from the Chinese Government attesting that the drugs were really needed for medical and scientific purposes. British direct exports were then replaced by "legal" exports from pharmaceutical companies and brokers in other European countries (Belgium, France, Germany, the Netherlands, Switzerland etc.) and large amounts of morphine also entered into China through Japan. In 1920, nearly 30 tonnes of morphine were shipped by Japan to China. According to the League of Nations, during a five-year period, from 1925 to 1930, at least 72 additional tonnes of morphine were smuggled into China.

Cocaine and opiates in patent medicines in Europe and in the United States of America

9. For centuries, medicines in Europe were prepared exclusively in pharmacies by pharmacists, who were responsible for the quality of medicines and for compliance with dispensing regulations, while the control of the pharmaceutical supply system was ensured by the supervision and inspection of pharmacies by medical officers. The marketing of industrially produced pharmaceutical specialities (proprietary medicines), which began in many countries in Europe in the last decades of the nineteenth century, created a new, unregulated situation. The problems became manifest first in the United Kingdom, where the marketing and free sale of patent medicines (which were secret remedies) had started earlier than in other European countries, where pharmacists preferred to dispense prescription medicines prepared by themselves rather than "ready-made" industrial products without prescription. In the United Kingdom, the easy availability of opiate-based patent medicines led to large-scale "home-drugging", which diminished substantially after the adoption of the Poisons and Pharmacy Act of 1908.

10. In the United States of America, there was no law regulating and limiting the sale of pharmaceutical preparations containing narcotic drugs until 1906. According to a 1902 report of the United States Government, only 3-8 per cent of the cocaine sold in New York, Boston and other metropolitan areas was used in medicine or dentistry. The number of patent medicines whose ingredients were kept secret was estimated at 50,000 in 1905 and a large proportion of those products contained cocaine, opium, morphine or other dangerous drugs. Similarly, in 1914, more than 1,000 manufacturers were marketing products containing either opium, morphine, heroin or cocaine. According to a government report, about 90 per cent of narcotic drugs were used for non-medical purposes. In 1914, annual per capita opium consumption in the United States was many times higher than in those European countries where the sale of opium and other pharmaceutical products was the monopoly of a well-regulated pharmacy system. In the United States, the Pure Food and Drug Act of 1906 required that any drugs contained in patent medicines be listed on the labels of those medicines, but the enforcement of that provision was ensured only in 1914, when the Harrison Narcotics Act was adopted. According to a government report, in

1912, the total number of cocaine and heroin fatalities in the United States exceeded 5,000. The unrestricted availability of those narcotic drugs was a major contributing factor.

11. In the nineteenth century, cocaine was used for medical purposes in Europe and the United States. It should be noted, however, that there was no scientific basis for many of its therapeutic uses in medicine (including its use for the treatment of opiate addiction). The inadequate knowledge of cocaine toxicity contributed to a large number of cocaine-related deaths and disabilities. By the 1890s, the medical use of cocaine had been superseded by its non-medical (or “recreational”) use. Cocaine snorting was a fashion in artistic circles and the higher classes of society. The large-scale export of cocaine to China, first from Europe and later also from Japan, started at around the same time; that cocaine was also not used for medical purposes. Between 1925 and 1929, at least 30 tonnes of cocaine were shipped annually into China, according to an estimate of the Permanent Central Board, the first predecessor of the International Narcotics Control Board. Ten years later, the medical requirements of the entire world (established by the League of Nations) totalled 1 tonne per year. In 1998, those requirements amounted to 400 kg.

B. The response to the situation: international cooperation

12. At the beginning of the twentieth century, drug use (or abuse) such as opium smoking in China, Burma, Persia etc., opium eating in India and other Asian countries, cannabis consumption in India (charas, ganja, bhang), Egypt (hashish) and Morocco (kif) and coca chewing among indigenous tribes in South America were regarded as “local” phenomena. At that time, only the licit and illicit export of opium (from Asian countries), morphine, heroin and cocaine (from European countries) to China and the smuggling of hashish into Egypt (out of other eastern Mediterranean countries) were considered to be international aspects of the drug problem. However, 100 years ago it was already evident that “consumer” (or “victim”) countries, such as China, were unable to deal with their enormous drug addiction problems without the cooperation of the countries producing and manufacturing drugs and that “supplier” countries could not deny their responsibility

Non-medical use of cocaine

in the development of drug addiction problems in other countries—problems that could spread to their own countries. The recognition of those facts led to the first form of international cooperation in the field of drug control.

First phase: cooperation through bilateral agreements

13. Agreements between the United Kingdom and China on the limitation of opium exports from India and the introduction of the system of authorization by the Chinese authorities for the import of opiates (morphine, heroin etc.) from the United Kingdom constituted the first steps towards the “internationalization” of drug control. The rationale of those steps was the belief that they would protect China from the unwanted import of opium and opiates.

14. It soon became apparent, however, that the opium supply from India was being replaced by large amounts of opium that were being smuggled into China out of other parts of Asia and that the supply of opiates from the United Kingdom was being replaced by large shipments of opiates from other European countries and Japan. This failure of the “bilateral approach” led to the development of international treaties.

Second phase: cooperation through multilateral treaties

15. The adoption in 1912 of the International Opium Convention was the consequence of the first international conference on narcotic drugs, held in Shanghai in 1909, which became known as the International Opium Commission. That conference, held almost 90 years ago, is rightly regarded as having laid the foundation for the current international drug control system.

16. The provisions of the first international drug control convention were intended to prevent the shipment of unwanted amounts of narcotic drugs to importing countries, but it was realized relatively soon

that, without a reporting system and without monitoring, it would not be possible to review the compliance or non-compliance of exporting countries with treaty provisions. At the same time, weak national controls in some exporting countries (and the activity of a few unscrupulous manufacturing and trading companies) hindered efforts to prevent opiates from being exported to countries with drug abuse problems.

Third phase: cooperation within the framework of an international drug control and reporting system

17. The above experiences led the international community to develop a third form of international drug control. In general, cooperation between Governments has frequently been hindered by political conflicts and confrontations, but there are signs that drug control constitutes one of the few exceptions. For example, the cold war did not prevent the east and the west from cooperating in the development and adoption of the Single Convention on Narcotic Drugs of 1961,⁴ the Convention on Psychotropic Substances of 1971,⁵ or the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.⁶

Control over the licit movement of drugs

19. The successful administration of the international control system (i.e. estimates and statistical systems), by the Board and its predecessors, in cooperation with Governments, has made effective control over the licit movement of narcotic drugs almost everywhere in the world. This covers all phases, from production, manufacture and trade to distribution and consumption. Today, there is virtually no diversion of manufactured narcotic drugs from the licit manufacture and international trade to the illicit traffic, even though the number of drugs under the international narcotics control regime has substantially increased.

20. In the case of psychotropic substances, the same degree of success has not yet been achieved. Due mainly to some industrial and commercial interests, the control provisions of the 1971 Convention in respect of international trade in substances listed in Schedules II, III and IV of that Convention are less stringent than those of the 1961 Convention. The reluctance of some major manufacturing and exporting States to adhere to the

control. In 1925, a compulsory reporting system was created and an independent international body (the Permanent Central Board) was established to monitor and supervise the compliance of Governments with treaty obligations. That approach remains a cornerstone of the international control system that is in place today.

C. Achievements

Consensus among Governments on the necessity of cooperation in drug control issues despite conflicts

The 1971 Convention and to implement even the minimal requirements of that Convention contributed to a considerable delay in the achievement of its aims. Despite those shortcomings, the 1971 Convention has contributed to the improvement of prescribing practices and drug utilization in many countries. The substantial reduction in the number of prescriptions of barbiturates and other hypnotics (in many countries, the drugs most frequently used in self-poisoning) and amphetamines is partially the result of the implementation of the provisions of the 1971 Convention. Large amounts of amphetamines were prescribed for the treatment of various conditions (e.g. depression, obesity), which is today considered medically inappropriate. In many countries, there were also many curious combination products, containing various mind-altering substances, including an amphetamine-type stimulant with a barbiturate. Such "mood-elevating" products were used for medical as well as non-medical purposes; that situation was very similar to the use of patent medicines containing cocaine or opiates at the beginning of the twentieth century (see paragraphs 9 and 10 above). The 1971 Convention has therefore played a substantial role in the elimination of licit but inappropriate drug use and of drug abuse.

21. Moreover, there has been an improvement in the situation because of the introduction of additional control and reporting requirements through resolutions of the Economic and Social Council. The voluntary compliance of almost all States with those requirements and the cooperation between Governments and the Board has led to a reduction in the large-scale diversion of most psychotropic substances.⁷

Efforts to reduce the illicit drug supply

22. The success of international cooperation in the control over the licit manufacture of and trade in narcotic drugs and most psychotropic substances has forced traffickers to resort to illicit drug manufacture.

23. Although the need for international cooperation against illicit drug manufacture and trafficking was realized long ago and the requirement for collaboration between Governments was included in international drug control treaties, concrete treaty provisions were formulated and adopted by the international community only in 1988.⁸ The latest international drug control

25. Substances convertible into narcotic drugs are under the control regime of the 1961 Convention, but the plenipotentiary conference that adopted the 1971 Convention excluded that possibility in the case of psychotropic substances. It is to the credit of the 1988 plenipotentiary conference that adopted the 1988 Convention that it opened the possibility for the control of some precursors of, for example, lysergic acid diethylamide (LSD), amphetamine-type stimulants and methaqualone. The inclusion of ergotamine, ergometrine, ephedrine and other substances into Table I of the 1988 Convention and the cooperation of Governments and the Board led, from 1990 to 1997, to the prevention of the illicit manufacture of millions of street doses of LSD and methamphetamine and other amphetamine-type stimulants. The control and monitoring of reagents and solvents (substances in Table II of the 1988 Convention, such as acetic anhydride and potassium permanganate) facilitated the detection of a number of clandestine laboratories engaged in the illicit manufacture of cocaine and heroin.

26. The Board is convinced that the extension of the scope of control of the 1988 Convention and the increasing cooperation between Governments and the Board will lead to a substantial improvement in the prevention of illicit drug manufacture. Concerted joint action by the international community aimed at eliminating the illicit cultivation of coca bush and opium poppy and the supply of coca leaves and opium to clandestine laboratories is a prerequisite to the fulfilment of that expectation.

Compliance with international conventions

treaty, the 1988 Convention, has been instrumental in furthering the implementation of concrete measures against trafficking in and abuse of drugs, including judicial cooperation, extradition of traffickers, controlled deliveries and action against the laundering of money derived from illicit drug trafficking.

24. Furthermore, cooperation between Governments and the Board in the control and monitoring of some precursors, chemicals and solvents frequently used in the illicit manufacture of narcotic drugs and psychotropic substances has already led to some promising results.

27. Ratification of or accession to the three main international drug control treaties can be regarded as the first sign of a Government's determination to contribute to the implementation of international drug control regulations. The entry into force of the international treaties depends on the speed of ratification. Because of the reluctance of several Governments to ratify the 1971 Convention, that Convention only entered into force five years after its adoption; however, the 1988 Convention entered into force already in 1990. The comparatively short "waiting period" is an indication of the increased commitment of Governments. The recent increase in the number of States that have become parties to all three international drug control treaties (see paragraphs 44, 48 and 50 below) is encouraging, as it suggests that universal adherence to those treaties can be achieved in the near future.

28. In the past, implementation of treaty provisions (as well as action against drug abuse and illicit trafficking) were frequently hindered by the absence of communication between national agencies, sometimes as a result of their reluctance to communicate with each other. In addition, in many countries matters related to narcotics were for decades left solely to law enforcement and/or regulatory agencies. A better understanding of drug-related problems has fostered cooperation between different professions and national authorities, which is of paramount importance. Today, the implementation of specific treaty provisions is facilitated by the involvement of national agencies and institutes with specific professional knowledge and competence. At the same time, however, the task has become more complex because of the involvement of a number of agencies and

institutes. Many countries are still at the stage of “learning” how best to coordinate all their activities.

29. Despite those difficulties, according to the experience of the Board, the compliance of national authorities with the provisions of the 1961 Convention, the 1971 Convention and the 1988 Convention is increasing; it is the basis for national drug control strategies in the vast majority of countries.

D. Challenges for the future

Availability and appropriate use of narcotic drugs and psychotropic substances for medical purposes

30. Morphine, codeine and other opioids used for the alleviation of human suffering are essential drugs. Their availability is therefore a priority public health issue (in conformity with the provisions of international drug control treaties). At present, however, there are enormous differences in the medical utilization of such drugs: mean average daily consumption (defined daily dose (DDD)) was 17,450 DDD per 1 million inhabitants during the period 1992-1996 in the 20 countries with the highest consumption and 184 DDD per 1 million inhabitants in the 20 countries with the lowest consumption. Unfortunately, similar differences exist in

32. The Board therefore calls upon Governments to ensure that the development of medical services and pharmaceutical supply systems is included among public health priorities. It is important that a distinction is made between illicit drug use on the one hand and inadequate selling and means of consuming drugs on the other hand. National health authorities should implement drug control measures and ensure that good prescribing and dispensing practices are established and followed and that patients are provided with complete and correct information.

Marketing and sale of products containing narcotic drugs or psychotropic substances

33. Evaluating the efficacy, safety and quality of a new pharmaceutical preparation before authorization is given to market that preparation has become a difficult

the case of other pharmaceutical classes of psychoactive drugs.

31. Narcotic drugs and psychotropic substances should be used in conformity with sound medical practices. Very high per capita consumption of a number of those drugs in industrialized countries suggests that there may be serious drug abuse situations notwithstanding the existence of laws designed to limit drug use to medical and scientific purposes. The prescribing of psychoactive drugs should be based on proper medical diagnosis and dosage, and self-treatment using such drugs should be avoided. At the same time, many developing countries are unfortunately not in a position to fulfil public health requirements: limited access to medical care may prevent a large segment of the population from complying with prescription obligations, and drugs are sold on “parallel markets” because of a lack of pharmacies and/or other health-care institutions (in some countries there is only one pharmacy for every 100,000 inhabitants). In addition, the cost of the general health-care system is increasing in many countries and Governments are encountering difficulties in financing the system. Some national health services, even in affluent societies, no longer reimburse patients for the costs of several classes of pharmaceuticals, including some narcotic analgesics and psychotropic substances (hypnotics, sedatives, tranquillizers). There is an imbalance between the overutilization of these effective drugs in some parts of the world and their definite underutilization in others.

and complex scientific process. The number of countries that are in a position to undertake this task is limited. Even more limited is the number of countries that are able to investigate and evaluate the abuse and/or dependence potential of new drugs or to monitor the utilization of those drugs for the detection of cases involving their abuse and/or dependence. Harmonizing drug registration requirements of the more developed countries and sharing results of the evaluation of new pharmaceuticals with other countries are excellent examples of international collaboration that could be systematically extended to the field of drug abuse in conformity with the provisions of international drug control treaties.

34. Political debate, community participation and academic discussions regarding policies in drug utilization are worthwhile activities in a civil society and should therefore be encouraged and promoted. However, the legitimacy of the marketing of narcotic

drugs or psychotropic substances for medical purposes should, as for any other medicine, be based on scientific data, and authorization should remain the responsibility of the competent national drug regulating authority. The Board wishes to draw the attention of Governments to various attempts to market as “food products” and “dietary supplements” preparations containing narcotic drugs or psychotropic substances. Some attempts have also been made to use loopholes in national pharmaceutical legislations or systems to circumvent drug control measures for products containing psychoactive substances.

The cannabis problem

35. The abuse of cannabis has become widespread in virtually all countries of the world only in recent decades. When the 1961 Convention was adopted, its aim was the elimination of large-scale traditional use of cannabis, bearing in mind the negative health and social consequences of the traditional use of cannabis in countries such as Egypt, India and South Africa. In those countries, the implementation of the provisions of the 1961 Convention has, for the most part, led to the elimination of the traditional use and abuse of cannabis. In countries where cannabis abuse has spread only in recent decades, there is a need for the 1961 Convention to be implemented more thoroughly, in particular through more effective prevention campaigns drawing attention to the dangers of cannabis abuse, thereby correcting the false image that such abuse has gained among a large segment of the youth population. The Board calls upon Governments to sponsor additional research on cannabis, to be carried out by qualified, impartial scientists, and to disseminate widely the results of such research.

Use of new technologies

36. New technologies have become indispensable to the development of drug research and clinical practices. Criminal investigations, including the identification and determination of drugs of abuse or the communication between competent control services, are facilitated by the use of new technologies. At the same time, however, the new possibilities offered by the flow of electronic information appear to be exploited more quickly and easily by criminal organizations: new drugs of abuse can be “designed” without difficulty by “manipulating” on a computer the molecules of drugs under the narcotics control regime, and methods used in illicit drug production or manufacture can be obtained from the Internet in a few minutes.

37. International and national regulatory controls are increasingly being threatened by the misuse of emerging technologies such as the World Wide Web. Drugs of abuse and related paraphernalia are blatantly sold on Web sites. Governments, in particular those that have allowed such Web sites to flourish on servers within their national boundaries, should work in close

cooperation with the Internet industry, community organizations, families and educators to set up a framework that will ensure that such emerging

technologies are not misused for the proliferation of drug abuse.

Treatment of drug addiction

38. In the past, in some countries, drug abusers were regarded as criminals. Today, in most countries, a distinction is made between drug abusers and drug traffickers, in conformity with the opinion of the Board. Drug law enforcement actions should mainly target illicit drug traffickers, and the treatment of addicts and the medical care of patients suffering from the psychic and/or physical consequences of drug abuse are alternatives specifically referred to in the international drug control treaties.⁹ Unfortunately, some States have opted to pursue policies and practices that are, at best, questionable from the point of view of their obligations under the international drug control treaties. The treatment of addicts is a difficult medical and humanitarian task that should be in line with sound medical practice and should not be used as an instrument to establish or maintain social control.

39. Drug substitution programmes were developed as a last resort for hard-core drug addicts who, for a variety of reasons, had not succeeded in overcoming their dependence using other treatment modalities. Such programmes should be regarded not necessarily as the ultimate goal but as an interim stage that would eventually lead to the development of a healthy, drug-free lifestyle and should be supported by psychosocial care.

E. Conclusion

40. The Board recognizes that drug regulations are not a panacea, that drug control measures alone cannot eliminate illicit drug trafficking and abuse. For that reason, it welcomes, for example, the adoption by the General Assembly at its twentieth special session of the Declaration on the Guiding Principles of Drug Demand Reduction (Assembly resolution S-20/3), as well as the efforts made by parties to the 1988 Convention to implement its provisions and reduce the supply of illicit drugs. Drug regulations, however, have in the past served an important function and continue to do so, especially in free-market economies: to channel and

limit drug use to medical and scientific purposes only while pursuing the public health interests of society as a whole. In that connection, the Board recalls also article 33 of the Convention on the Rights of the Child (General Assembly resolution 44/25, annex), which reads as follows: "States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances."

41. Illicit crop cultivation and illicit drug production, manufacture and trafficking by national and international criminal organizations have taken on enormous dimensions. It is understandable that the question of whether it is still worth while to spend money on drug control is frequently raised. Would it not be more economical to do away with all drug regulations and other related efforts and to leave it to market-economy forces to regulate the situation at no cost to society? In the opinion of the Board, this is the wrong question; it is similar to questioning whether it is economical to prevent car accidents or to treat infectious diseases. History has shown that national and international control of drugs has proved to be an efficient tool for reducing the development of drug dependence and is therefore the choice to be made.

42. In the case of narcotic drugs, the original aim of the international drug control regulations was achieved: today, there are only a few isolated cases involving the diversion of narcotic drugs from licit channels. Similar results are being achieved in the control of psychotropic substances pursuant to the 1971 Convention. Had it not been for those controls, the addiction epidemics in some countries in the first few decades of the twentieth century would have continued and similar situations would have developed in many other countries. It can be assumed that without international and national regulations, the extent of the non-medical use of narcotic drugs would have reached the dimensions of the use of any other psychoactive substances that are sold and used with little or no restriction. The social acceptance of the use of tobacco, the high prevalence of smoking (up to 65 per cent of the adult population in

some countries) and a very high morbidity associated with use of tobacco and alcohol together result in the premature deaths of millions of individuals each year. Furthermore, alcohol-related criminality and trafficking 43. Pharmaceuticals, above all prescription drugs and especially those containing narcotic drugs or psychotropic substances, cannot be directly compared with consumer goods because, in the case of pharmaceuticals, the “consumer” is not necessarily qualified to establish a medical diagnosis, select the specific drug for the specific disease and determine the appropriate dosage regime, while taking into consideration possible side effects, including (in the case of narcotic drugs and psychotropic substances) drug abuse and drug dependence. The consequences of the unregulated sale of pharmaceutical products are well documented in the United States, where, before 1906, the use of drugs was determined only by market forces (see paragraph 10 above) and the results of the free availability of narcotic drugs in China (see paragraphs 4 and 5 above). In 1858, all of the national control efforts that had been made by the Chinese authorities in a period lasting over a century (the edicts of 1729, 1799, 1808, 1809 and 1815) were undermined by the legalization of the drug trade imposed by colonial Powers. Such situations should not be allowed to be repeated.

in products containing tobacco or alcohol have reached significant levels.