Desirable Characteristics of National Pain Strategies: Recommendations by the International Association for the Study of Pain

In the past four decades there have been significant advances in our understanding of the complexity of the nervous system and in our knowledge about the causes of pain. Research has established that there are essentially two types of pain (acute and chronic). There is both cancer-related and noncancer pain. Effective treatments exist; nevertheless, the best available evidence indicates a major gap between an increasingly sophisticated understanding of the pathophysiology of pain and the widespread inadequacy of its treatment.

In many nations, this gap is unnoticed and unmeasured. Many public health agencies seem unaware of the scale of the problem of unresolved pain, with the result that the population’s needs remain unaddressed, even though low-cost solutions may be available.

This gap has prompted a series of declarations and actions by national and international bodies advocating better pain control (see the Summary Chart for examples). These calls to action are based on three propositions:

- Pain, no matter which type, is inadequately treated for a variety of cultural, attitudinal, educational, political, religious, economic, and logistical reasons.
- Inadequately treated pain has major physiological, psychological, economic, and social ramifications for patients, families, and society.
- It is within the capacity of all developed and many developing countries to significantly improve the treatment of pain without incurring substantial costs, through addressing some of the barriers that exist.

The impact of inadequately treated pain appears remarkably similar, no matter where in the world it is measured [3,6,7,15,18,21,22,25].

- One in five people has moderate to severe chronic pain.
- One-third of these people have experienced lost ability to perform wage-earning or other work.

Imaging studies have shown that persistent pain is associated with significant functional, structural, and chemical changes in the brain, thus putting such pain into the realm of a disease state [24]. Patients who have chronic pain disorders with known causes (e.g., osteoarthritis or cancer) or unknown causes (e.g., nonspecific low back pain) have altered cerebral pain processing and loss of gray matter, leading to impaired function [1,20,26]. Increasing evidence shows that chronic pain is in fact a separate disease entity with associated patterns of central nervous system abnormalities. Yet the considerable breakthroughs in scientific knowledge about the phenomenology, pathophysiological mechanisms, and related treatment advances for pain diseases and disorders are barely acknowledged in medical training, with the result that people with severe, poorly relieved pain are often stigmatized and disbelieved. The Declaration of Montreal highlights the need for people in pain to assert their rights to care.
Advances in medical knowledge have led to improved understanding of how to better manage pain, in terms of both primary and secondary prevention of chronic disability and improved multidisciplinary management of those most severely affected by chronic pain. However, studies [7,19] show that:

- Fewer than 50% of patients with cancer pain receive effective relief
- Fewer than 50% of patients with acute pain receive effective relief
- Fewer than 10% of patients with chronic noncancer pain gain access to effective management

Many institutions such as the National Institutes for Health (NIH) in the United States and the National Institute for Health and Clinical Excellence (NICE) in the United Kingdom have published guidance on cost-effective interventions for the management of pain. Summarizing the literature [4,11,14,28], we now know that:

- 90% of acute pain can be successfully treated at low cost
- 75% of cancer pain can be successfully treated at low cost
- 80% of patients with chronic noncancer pain can now be effectively managed

Worldwide, if we continue to fail at effective pain management, we will continue to pay a staggering and unnecessary price [8].

The International Association for the Study of Pain (IASP) supports the view that every country should have a pain strategy that specifies the extent of the problem and what should be done about it. This document sets out recommendations for the essential elements of any national pain strategy and for the process of achieving a strategy. It accompanies the Declaration of Montreal, which asserts the human rights of those in pain. It is hoped that this document will act as an impetus to clinicians, educators, administrators, and governmental or professional organizations involved in the establishment and maintenance of standards for pain services to take action to prevent the continued waste of millions of lives and resources.

**National Strategy Development**

IASP members submitted health policies on pain in 19 countries to a review by a working party. Seven countries were found to have a comprehensive strategy to address the management of pain, and the remainder had strategies focusing mainly on opioid control. These strategies are contained within the Summary Chart.

Combined experience has demonstrated that several steps are helpful in developing a national strategy. The following points represent a distillation of these steps.

1. **Understanding the scale of the problem posed by poorly managed pain**

Excellent large-scale surveys in many countries have established that chronic noncancer pain ranks as the third most costly health care problem after cancer and cardiovascular disease and that the problem is costlier in developing countries [15,25]. Poorly relieved pain also leads to accelerated mortality [23].
In spite of this information, the extent of the problem is poorly understood because pain and its effects are being hidden in other forms of measurement. As it is often initially associated with other disease processes, pain is often inadequately recorded, both in clinical records and in the administrative coding that is often used as a source for epidemiological studies. For example, the World Health Organization’s “Global Health Risks,” which aims to identify forthcoming major health risks to the world, mentions only the impact of low back pain on work [31]. Without generating new data, governments may fail to appreciate the size of the problem. Countries should carry out a basic health survey to understand this problem by asking questions specifically about pain, its management, and its impact. This information serves as a useful baseline from which to measure the impact of any interventions a government may introduce [12].

2. Understanding the barriers to effective pain management

There may be professional, public, or system barriers. Common professional barriers include a lack of knowledge and skills, as well as inappropriate attitudes and behaviors that demonstrate a lack of understanding of the problem. System barriers may include a lack of resources, outmoded financial incentives, or poor coordination of care. Population health knowledge and awareness may be poor. Taboos may exist toward both those who seek treatment for their pain and some of the treatments that may benefit them. There may be problems with drug availability, training of health care workers, or gaps in policy development. A lack of resources to ensure coordination of pain management between both primary and secondary care and health care services and social services may exist [19].

Specific examples of barriers include:

- Educational gaps: national surveys in Canada and the United Kingdom have identified that veterinarians receive more training in pain management than do health care professionals who care for people [9,30].
- Best-practice pain management often requires coordinated interdisciplinary assessment and management, yet current reimbursement and insurance arrangements mean that treatments with limited evidence of efficacy, including some surgeries and invasive medical treatments that carry the risk of complications or dependency, are often favored over a combination of less invasive and less costly approaches that promote independence.
- Excessive waiting times for treatment in chronic pain can lead to a deterioration in health [16,29], risking aggravation of the pain condition and further decreases in quality of life, eventually requiring more expensive interventions.
- Pain research is grossly underfunded, considering the burden of illness [5,17].
- There is a lack of public health focus on pain as a priority [10].

3. Developing a clear plan to deliver change

Desirable characteristics of any plan, as recommended by the International Association for the Study of Pain, have been classified into four broad areas:

- Pain research
• Pain education
• Patient access and care coordination
• Monitoring and quality improvement

It is essential to
• Identify those who have the capacity to deliver change
• Establish a timeline for achieving change
• Measure the impact of change on a health system and on the society in which it operates

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<td><strong>Pain Research</strong></td>
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<td>Epidemiological</td>
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<td>Translational/ basic science</td>
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<td><strong>Pain Education</strong></td>
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<tr>
<td>Undergraduate/ medical school</td>
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<td>GME-primary care</td>
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<td>CME-physicians</td>
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<td>Allied health</td>
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<tr>
<td>Public awareness</td>
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<td><strong>Patient Access and Care Coordination</strong></td>
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<td>To care</td>
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<tr>
<td>To medicines</td>
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<tr>
<td>Characteristics</td>
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<td>To information</td>
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<td>Specialist referral</td>
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<td>Interdisciplinary approach</td>
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**Monitoring/Quality Improvement**

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<td>Time to care</td>
<td>Setting standards for access times and work plans that allow sufficient time.</td>
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<td>Quality of service</td>
<td>Patient experience should be routinely sought; there should be a reduction in waiting times for treatments.</td>
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<td>Quality of life</td>
<td>Improvements in the individual patient’s quality of life, according to both generic and disease-specific measures.</td>
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<td>Economic burden</td>
<td>Monitoring should include work absence due to pain, prescription costs, urgent care, and use of other services.</td>
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<td>Special needs</td>
<td>Special populations include the very young and very old, victims of torture, those with learning difficulties, ethnic minorities, and impaired persons.</td>
<td>Providers and commissioners of health care</td>
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**References**


