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Improving access to adequate pain management in Taiwan

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ABSTRACT

There is a global crisis in access to pain management in the world. WHO estimates that 4.65 billion people live in countries where medical opioid consumption is near to zero. For 2010, WHO considered a per capita consumption of 216.7 mg morphine equivalents adequate, while Taiwan had a per capita consumption of 0.05 mg morphine equivalents in 2007. In Asia, the use of opioids is sensitive because of the Opium Wars in the 19th century and for this reason, the focus of controlled substances policies has been on the prevention of diversion and dependence. However, an optimal public health outcome requires that also the beneficial aspects of these substances are acknowledged. Therefore, WHO recommends a policy based on the Principle of Balance: ensuring access for medical and scientific purposes while preventing diversion, harmful use and dependence. Furthermore, international law requires that countries ensure access to opioid analgesics for medical and scientific purposes. There is evidence that opioid analgesics for chronic pain are not associated with a major risk for developing dependence.

Barriers for access can be classified in the categories of overly restrictive laws and regulations; insufficient medical training on pain management and problems related to assessment of medical needs; attitudes like an excessive fear for dependence or diversion; and economic and logistical problems. The GOPI project found many examples of such barriers in Asia.

Access to opioid medicines in Taiwan can be improved by analysing the national situation and drafting a plan. The WHO policy guidelines Ensuring Balance in National Policies on Controlled Substances can be helpful for achieving this purpose, as well as international guidelines for pain treatment.

1. Introduction

Access to opioid medicines and other medicines controlled as substances that can cause dependence is problematic around the world. In fact, there is a global pain crisis. In 2010, 4.65 billion people lived in countries where medical opioid consumption is near to zero on a total world population of 7 billion.[1] The World Health Organization (WHO) estimates that worldwide every year 5.4 million cancer patients, 1 million HIV pain patients, 0.8 million people with lethal injuries and between 8 and 40 million surgery patients are not treated for their pain.[2] For the treatment of moderate to severe pain, opioid agonists are the main stay as can be concluded from international pain guidelines such as the WHO Cancer Pain Relief guidelines (1996) or the WHO Guidelines on the Pharmacological Treatment of Persisting Pain in Children with Medical Illnesses (2012).[3,4] These guidelines recommend the availability of a variety of opioids, in order to be able to switch from one to another if the patient does not react well. The WHO Model List of Essential Medicines and the WHO Model List of Essential Medicines for Children list a number of morphine preparations and also mention that in addition, as alternatives oxycodone and hydromorphone should be available.[5,6] These two substances should be considered as examples, and other opioid analgesics will do as well.

Seya et al. studied opioid analgesic consumption around the world. The authors defined “adequate consumption” as the average per capita consumption of five opioid agonists (morphine, fentanyl, hydrocodone, oxycodone and pethidine) in the top-20 countries of the Human Development Index, measured as “morphine equivalents”.[7] For 2010, this average is 216.7 mg morphine equivalents.[1] Pan et al. published trends in opioid consumption data for Taiwan (2002 – 2007) and opioid consumption increased over this period. However, they show that the per capita consumption of all strong opioids available in Taiwan (fentanyl, morphine and pethidine) together is only 0.05 mg morphine equivalents for 2007.[8] In spite that the method by Seya et al. is slightly different and that the most

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recent figures for Taiwan date from 2007, it is obvious that there is a huge disparity of approximately a 4300 times between the adequate level and the Taiwanese consumption level. Moreover, it should be noted that there is still considerable use of pethidine in Taiwan (around 5% of the total strong opioid consumption), although this medicine was deleted from the WHO Essential Medicines list around 15 years ago because of its side effects. Moreover, there is still considerable consumption of codeine (around 10% compared to the consumption level of strong opioids), which is a weak opioid subject to inter-individual metabolic differences and therefore its effect is unpredictable.

2. Arguments for a higher consumption level

Because of the Opium Wars in the nineteenth century, it is understandable that the use of opioids is sensitive in Eastern Asia even today. Even in Japan, like Taiwan one of the most developed countries in the region, consumption levels are only 15% of the adequate level; consumption levels in other countries in the region are between Taiwan and Japan.[1]

For the prevention of harmful use of opioids and other substances that can cause dependence, the international community started a system of international control of these substances about 100 years ago.[9] Today, most strong opioids are regulated under the Single Convention on Narcotic Drugs, with the exception of buprenorphine, which is regulated under the United Nations Convention on Psychoactive Substances.[10] Worldwide the focus has been on the prevention of harmful use and dependence for decades. However, both conventions state in their preambles that these substances are indispensable for the relief of pain and suffering and that adequate provision must be made to ensure their availability for medical and scientific purposes.

For this reason, the WHO recommends to focus policies on the total public health outcome and not only the prevention of dependence. It is obvious that this comprises also the positive effects of medicines when rationally prescribed and used. WHO described this as the "Central Principle of Balance": "The central principle of 'balance' represents a dual obligation of governments to establish a system of control that ensures the adequate availability of controlled substances for medical and scientific purposes, while simultaneously preventing abuse, diversion and trafficking. Many controlled medicines are essential medicines and are absolutely necessary for the relief of pain, treatment of illness and the prevention of premature death. To ensure the rational use of these medicines, governments should both enable and empower healthcare professionals to prescribe, dispense and administer such medicines according to the individual medical needs of patients, and to ensure that a sufficient supply is available to meet those needs. While misuse of controlled substances poses a risk to society, the system of control is not intended to be a barrier to their availability for medical and scientific purposes, nor interfere in their legitimate medical use for patient care."[11]

In addition to this dual obligation for governments, several human right treaties enshrine the right to people to have access to opioid analgesics when their health so requires. In general terms, the right to health is included in the Constitution of WHO, the International Covenant on Economic, Social and Cultural Rights (ICESR), the Convention on the Rights of the Child and other international treaties. The authoritative General Comment 14 gives a right to have access to essential medicines, which includes a number of opioid analgesics, and that the elderly and the dying be spared avoidable pain.[12] More recently, a resolution by the World Health Assembly affirmed "… that access to palliative care and to essential medicines for medical and scientific purposes manufactured from controlled substances, including opioid analgesics such as morphine, in line with the three United Nations international drug control conventions, contributes to the realization of the right to the enjoyment of the highest attainable standard of health and well-being".[13]

Furthermore, not providing adequate pain management to a patient if this is possible, also relates to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT). The United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment considers that "the de facto denial of access to pain relief, if it causes severe pain and suffering, constitutes cruel, inhuman or degrading treatment or punishment." "Given that lack of access to pain treatment and opioid analgesics for patients in need might amount to cruel, inhuman and degrading treatment, all measures should be taken to ensure full access and to overcome current regulatory, educational and attitudinal obstacles to ensure full access to palliative care."[14]

Contrary to what many people think, analgesic treatment with opioids does not cause dependence easily. A meta-analysis of 115 studies among patients treated with opioids for chronic non-cancer pain for at least six months found signs of opioid dependence in only 0.05% of the patients (1/2,042) and abuse in only 0.43% (3/684).[15] A Cochrane study concluded that the available evidence suggests that opioid analgesics for chronic pain conditions are not associated with a major risk for developing dependence.[16]

Common sense also tells us that if pain is well assessed and the prescribed amount of opioids is at the right level – i.e. not too low, but also not too high – patients will prefer to have the pain treated and they will therefore not divert their medicines.

3. Barriers for access to pain management

The mechanisms that impede access to adequate pain management vary by country. WHO distinguishes four categories of barriers:

- Overly restrictive laws and regulations and inadequate policies: rules often do not prevent abuse, dependence and diversion but they do create a barrier for medical access. The legal barriers can be subdivided in conceptual barriers; general barriers; barriers that affect prescribing, dispensing, manufacturing, usage, trade and distribution, affordability or prosecution; language barriers and other barriers; often, governments do not have policies to ensure that patients receive rational treatment with controlled medicines.
- Insufficient medical training on pain management and problems related to assessment of medical needs;
- Attitudes like an excessive fear for dependence or diversion;
- Economic and logistical problems.

In most countries a mix of these barriers make it difficult for patients to find treatment for their pain. Only if all barriers are addressed together, it will be possible to change this situation.

The Global Opioid Policy Initiative (GOPI) made an inventory of barriers for access around the world.[17,18] For Asia, it frequently found barriers such as:

- Limited patient eligibility (to whom opioids can be prescribed): in some countries opioids cannot be prescribed to outpatients and/or hospice patients or only with a special permission.
- Limitations to the medical specialties who can prescribe opioids: in many countries only a limited number of specialties are allowed to prescribe and often only with a special permit. In China a family doctor is not allowed to prescribe opioids and also in most countries pharmacists and nurses are not allowed to do so.