



UNRELIEVED PAIN IS A MAJOR GLOBAL HEALTHCARE PROBLEM

“Pain is a major healthcare problem. Although acute pain may reasonably be considered a symptom of disease or injury, chronic and recurrent pain is a specific healthcare problem, a disease in its own right”
(<http://www.efic.org/eap.htm>)

Acute pain is a major problem after surgery and trauma.

- Major advances have improved management of acute pain, but more than 50% of patients still have severe to intolerable pain after surgery and trauma.
- Poorly controlled post-operative pain is a risk factor for heart attacks, pneumonia, and dangerous blood clots after surgery.
- Severe acute pain after surgery also increases the risk of persistent pain after surgery. Chronic pain after surgery and trauma is common and debilitating.

Chronic or recurring pain afflicts one in five adults.

- Pain that persists or recurs for more than 3 months is termed chronic.
- Surveys of households reveal that over a third have chronic pain sufferers in Europe (36%) and the USA (43%).
- Large scale studies in Europe, North America, Australasia and other regions disclose that one in five of the adult population suffers from chronic moderate to severe pain.
- Pain prevalence increases with age, and is higher in females and in those with physically strenuous work or less education. In at-risk groups the occurrence of chronic pain is even greater.

Causes and duration of chronic non-cancer pain.

- Three groups of conditions are large components of the burden of chronic pain: osteo- and rheumatoid arthritis (40%), operations and injuries (25%), and spine problems (20%).
- Other causes include headaches, neuropathy of diabetes or toxins (including alcohol), neurological disorders and stroke, and HIV/AIDS.
- An increasing number suffer chronic pain from deliberate physical harm: violence, war (e.g., landmines) and torture.
- 19% of the general adult population of Europe have had moderate or severe chronic pain for a median of 7 years. One in five of those with chronic pain had suffered for over 20 years.

Chronic pain impairs everyday activities, social functions, and quality of life. Pan-European and Danish studies found:

- Between half and two-thirds were less able or unable to exercise, enjoy normal sleep, perform household chores, attend social activities, drive a car, walk or have sexual relations.
- One in four reported that relationships with family and friends were strained or broken.
- One in three were less able or unable to maintain an independent lifestyle.
- One in five had depression because of pain.
- 17% suffered so badly that some days they wanted to die.
- 39% felt their chronic pain was inadequately managed. In such cases half felt their doctor did not view their pain as a problem.

Chronic pain carries great economic cost- direct and indirect.

- The financial cost of chronic pain is roughly the same as cancer or cardiovascular. The financial cost of chronic pain is roughly the same as cancer or cardiovascular disease. Low back pain alone is a major economic burden in developed countries. These costs include:
 - expenses of health care and medication.
 - job absenteeism, impaired job performance of the sufferer and disrupted performance of co-workers.
 - loss of income.
 - non-productivity in the economy and in the sufferer’s home.
 - financial burden on family, friends and employers.
 - worker compensation costs and welfare payments (social transfers).

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- Studies cited above also found:
 - two-thirds of chronic pain sufferers were less able or unable to work outside of the home.
 - one in four had changed job or job responsibility.
 - one in five had lost their job.
 - chronic pain increases the risk of job loss by seven fold.
- The economic and social burden of chronic pain is especially great In developing nations due to:
 - infections such as HIV/AIDS or leprosy.
 - chronic nerve injury from the dismembering traumas of war or landmine injury.
 - genetic disorders such as sickle disease.
 - nutritional deficiencies or toxins such as alcohol.

WHY IS THE GLOBAL DISEASE BURDEN OF CHRONIC PAIN UNDERESTIMATED?

- Many conditions identified by the WHO as causing the greatest global disease burden in fact do so through acute or chronic pain. These include depression, trauma such as falls or motor vehicle accidents, and osteoarthritis. A 14-nation WHO study reaffirmed the overlap between persistent pain and psychological disorders such as depression. This same study found that about one in ten people develop a chronic pain condition every year (Gureje et al 1998).
- Conditions often known to be painful especially cancer, diabetes, HIV/AIDS, sickle disease and leprosy are now recognized to be widely under-diagnosed and under-documented. Pain in such conditions is known to be widely under-assessed and under-treated even in the most advanced countries.
- Data on pain in many conditions has not even been sought until recently. Medical myths fostered views that infants do not experience pain, that pain is inevitable and so its treatment is futile in the elderly, or that third-degree burns do not hurt. Careful observations have disproved such myths. The widespread burden of chronic pain following surgery has not been defined until recently.

WHAT ARE THE BARRIERS TO CHRONIC PAIN ASSESSMENT AND TREATMENT?

- **Ignorance -- lack of knowledge or even awareness.** This knowledge gap affects healthcare providers, policy makers, patients, and their families.
- A recent pan-European patient survey found that one in four with moderate or severe chronic pain stated that their doctor never asked about pain, did not think the patient had a pain problem, or if pain were discussed, spent too little time and did not know how to treat it.
- **Lack of available and affordable drugs, particularly opioids,** and other pain-relieving measures. This lack reflects inadequate resources as well as restrictive regulatory measures. Thanks to efforts by WHO during the last two decades, the global availability of opioid analgesics has improved. Yet despite WHO recommendations, in most developed countries opioids are widely underprescribed for severe cancer pain. And, cancer pain is but a small fraction of the total burden of pain. For patients with chronic non-cancer pain, these effective analgesic drugs are not prescribed at all in large parts of the world.
- **Racial or ethnic minority status** predict substandard access to appropriate pain assessment and treatment in the United States and Western Europe. For example, strong opioids for pain relief are unavailable in many pharmacies in minority neighborhoods (Morrison RS et al, N Engl J Med 2000;342:1023-6.)
- These barriers are worse in resource-limited settings: developing countries and low socioeconomic sectors of developed countries. Economic strains upon the health care systems in many developing countries preclude effective treatment of pain.

“CHRONIC PAIN IS A MAJOR HEALTH CARE PROBLEM, A DISEASE IN ITS OWN RIGHT” (<http://www.efic.org/eap.htm>)

- Acute, cancer-related, and chronic noncancer pain, along with headache impair health and quality of life of the sufferer and his/her family, and diminish society’s economic well-being.
- Chronic pain should be recognised as not just a symptom but in important condition that often becomes a disease in its own right.
- Persistent pain must be treated with the same priority as the disease that caused it.

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WHAT TO DO NOW?

- The WHO defines health as not simply the absence of disease, but rather a state of wellness. This definition has guided the efforts of those concerned with social and community health for over fifty years. It has led to, and fits perfectly with, excellent WHO programs such as the global action against cancer pain. WHO has already improved awareness and treatment for cancer pain and pain due to HIV/AIDS.
- Other comprehensive efforts are now needed to extend the cancer pain and HIV/AIDS work, and to manage the much bigger problem of chronic non-cancer related pain, and pain in at-risk groups. Chronic non-cancer pain increases with age, and the WHO document on management of pain in the elderly (Davis and Higginson 2004) is an important signal for policy makers to assign a high priority to management of such pain.
- Addressing the global burden of pain need not involve costly, high-tech interventions but does require global education of health professionals, patients, and their families to best apply available, generally low-cost yet effective therapies. Such efforts will be advanced by expanding the collaboration between interested international partners.
- The International Association for the Study of Pain (IASP) has a long commitment and record of accomplishments in meeting global needs for pain education. IASP and its chapters support fellowships, travel grants, and provision of texts and journals for members in currency-restricted countries. IASP has developed and disseminated curricula on pain for medical, dental and nursing students worldwide. IASP has an infrastructure of members around the world who contribute to its educational efforts through its journals, clinical bulletins. Through geographically and professionally diverse activities, IASP's 67 national and regional chapters are now conducting pain awareness campaigns. A global pain awareness campaign by IASP, concerned with improving understanding and management of unrelieved pain, was initiated during the week of 13-19 October 2003, and is to be repeated every year.
- EFIC, i.e. The European Federation of 28 national and regional Chapters of IASP, started a European Initiative Against Pain 5 years ago, to promote changes of attitude amongst EU stakeholders in the field of public health, and in the public at large, that chronic pain is not merely a symptom, but a disease in its own right. This is being followed up with a call for specialization (or subspecialization) in pain medicine, revision of training curricula of medical doctors and allied healthcare professionals to include more education on pain assessment and management, establish practical treatment protocols or clinical paths to better pain management. European governments and governmental organizations will be encouraged to dedicate greater resources to research on biological mechanisms of chronic pain, the epidemiological analyses of the nature and extent of the pain health problem.
- Other NGOs with official relationships to WHO, such as the World Federation of Societies of Anaesthesiologists (WFSA), concerned especially with acute pain and its many short- and long-term consequences, will be invited to join in these activities. These include the NGO "Douleur sans Frontières," led by Alain Serrie and active in French-speaking Africa.

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(These Tables/Fact-boxes (appropriately edited) may or may not be included in the final Fact sheet):

Table 1

- 19% in Denmark, n = 12 333 (Eriksen J et al Pain 2003 - in press)
- 19% in pan-Europe, n = 46,394 (Breivik H et al. 2003- submitted)
- 18.5% in Australia, n = 17,500 (Blyth et al. Pain 2001)
- 21.5% world wide, n= 5438 (Gureje et al (WHO) 1998; Harstall and Ospina- Pain: Clinical Updates, 2003).

Table 2

European studies on prevalence of chronic pain

Anderson et al 1993, Sweden	N= 1609	50%	Postal	Pain > 6 months
Anderson et al 1993, Sweden	N= 1609	55%	Postal	Pain > 3 months
Bowsher et al 1991, UK	N= 1037	11.5%	Telephone	Pain > 3 months
Catala et al 2002, Spain	N= 50009	23%	Telephone	Pain > 3 months
Elliot et al 1999, Scotland	N= 3605	50%	Postal	Pain > 3 months
Perquin et al 2000, Netherlands	N= 5423	25%	Postal	Pain > 3 months
MacFarlane et al 1997, UK	N= 1953	13%	Postal	Pain > 3 months
Croft et al 1993, UK	N= 1340	13%	Postal	Current Wide Spred Pain > 3 months
Croft et al 1993, UK	N= 1340	35%	Postal	Pain > 3 months
Brochet et al 1998, France	N= 741	33%	Face-to-face	Pain > 6 months

Table 3

A point prevalence estimate as high as 57% was derived from a random dialing telephone survey of 1004 adults conducted by a nonprofit group in mid-2003 in the USA (Hart D et al, 2003, www.researchamerica.org)

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