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Vol. XX, Issue 7 December 2012

Interdisciplinary Chronic Pain Management: International Perspectives

Of all approaches to the treatment of chronic pain, none has a stronger evidence basis for efficacy, cost-effectiveness, and lack of iatrogenic complications than interdisciplinary care.[1–9] Initially developed in the 1940s at Tacoma General Hospital by John Bonica and colleagues in response to their recognition that the complexities of chronic pain required a complex biopsychosocial approach,[10] interdisciplinary programs have subsequently spread throughout the world. Although the composition of modern interdisciplinary treatment teams may vary to some degree, Okifuji and colleagues[2] have noted that the typical treatment provided includes three common elements: (1) medication management, (2) graded physical exercise, and (3) cognitive and behavioral techniques for pain and stress management. Most critical is the understanding that chronic pain is a disease of the *person*, and that a traditional biomedical approach cannot adequately address all of the pain-related problems of this patient population.[11]

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While perhaps initially an American phenomenon, interdisciplinary chronic pain management programs have certainly thrived in other areas of the world. In 1999, it was estimated that there were over 1000 interdisciplinary pain management programs in the United States.[12] This number has dropped dramatically, with the number of programs currently operating estimated at 150.[13] If the Institute of Medicine Report on Relieving Pain in America's figures are accurate, approximately 100 million Americans suffer from chronic pain.[14] These data suggest that there is approximately one interdisciplinary program for every 670,000 chronic pain victims in the United States. In other developed nations, however, the availability of interdisciplinary chronic pain care appears to be increasing dramatically.

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To assess the availability of interdisciplinary pain treatment in other nations, emails were sent to representatives of the chapters of IASP in Australia, Belgium, Canada, Denmark, Germany, Israel, Italy, the Netherlands, New Zealand, Spain, Sweden, and

Table I
Access to interdisciplinary pain management services in different countries

Nation	Population	No. Clinics	Publically Funded Clinics	Privately Funded Clinics	No. Citizens/ Clinic	Average Wait for Admission	Change in No. Clinics in Past Decade
Australia	23 million	90	Some public, some private, some mixed	Some public, some private, some mixed	255,555	6 months (median)	Increase
Belgium	11 million	9	9	Private clinics also exist*	1,222,222	7 months	Increase
Canada	35 million	203	122	81	172,413	6 months (public), 2 weeks (private)	Increase
Denmark	5.6 million	10	5	5	560,000	18 months (public), 1 month (private)	Increase
England and Wales	56 million	138	138	Private clinics also exist*	405,797	4-5 months	Increase
France	65 million	81	78	3	802,469	1.5 months	Increase
Israel	8 million	11	8	3	727,000	3 months (mean)	Increase
Netherlands	17 million	7	0	7	2,438,571	2.5 months	Increase
New Zealand	4.4 million	10	10	Private clinics also exist*	440,000	4 months	Increase
Spain	46 million	6	6	0	7,666,666	3 months (mean)	Increase
Sweden	9.5 million	28	25	34–5	339,285	1.3 months (median)	Increase
United States (non-VHA†)	292 million	90 (est.)	0	90	3,244,444	Unknown	Decrease
United States (VHA†)	21.8 million	59	59	0	369,491	Varies	Increase

* No data on their numbers were available.
† Veterans Health Administration.
Note: These results were provided by pain societies or individuals within pain societies, and their exact accuracy cannot be verified. For some nations, the information that was provided was incomplete or represented national pain society estimates. Additionally, some of the individuals who were contacted did not respond, or replied that the data were unavailable. Finally, definitions of "interdisciplinary pain management" clearly vary between nations, although efforts were made to identify the number of programs that involve a minimum of a physician, a mental health professional, and a physiotherapist. Accordingly, the data represent estimates of access to interdisciplinary care for some nations.

the United Kingdom. Each correspondent was asked to report the total number of interdisciplinary programs; the number of programs that were publically vs. privately funded; the average period of time that a pain patient typically was required to wait prior to evaluation and treatment; and whether the number of programs in the country had increased, decreased, or remained the same over the past decade. Population figures were obtained from each nation's most recent census data, and the number of citizens per interdisciplinary program was calculated in order to assess relative availability of such treatment by nation. Results from the chapter representatives who responded to these queries are summarized in Table I.

The data presented in Table I speak for themselves in regard to access to interdisciplinary pain management services. The data indicate that access is best in Canada, yet numerous journal articles have addressed access problems in that nation over the past 5 years.[15–21] Certainly, the waiting time for publically funded interdisciplinary programs in Canada is long, as it is in some of the other nations for which data were collected.[22,23] While this situation is not ideal, it is far better than the one in the United States, where interdisciplinary programs are simply not available for the vast majority of chronic pain sufferers. Moreover, representatives from pain societies throughout the developed world reported that the number of programs in each country has increased over the past decade—in some instances dramatically—unlike in the United States, which, with the exception of the Veterans Health Administration (VHA) system, has witnessed all but the demise of interdisciplinary programs. Finally, of all of the nations from which data were collected, the only one other than the United States that does not have a national health service is the Netherlands—with the data indicating extremely poor access to interdisciplinary pain care in that nation.

Although a number of stakeholders in American pain medicine have long perpetrated the myth of the superiority of medicine in the United States, the World Health Organization's (WHO) ranking of the American system as only the 37th best in the world in 2000[24] has helped enlightened Americans recognize that our system is failing badly. Perhaps in no area of medicine is the American system more compromised than in the treatment of pain. Data indicate that Americans consume more than 80% of the world's prescription opioids, despite the fact that Americans comprise only 4.6% of the world's population,[25] which is not surprising given the "pill mentality" that has become rampant in the United States. Chronic opioid therapy, despite its lack of an evidence basis, an emergent body of literature elucidating the severity of its iatrogenic complications, and the well-documented problems of prescription medication abuse and overdose deaths, continues to be practiced widely in the United States—which is certainly not the case in other developed nations. It has been noted that the United States differs from nations with national health insurance systems, as these systems require that treatments used for pain have empirically demonstrated clinical efficacy and safety.[26] This difference between nations with and without national health insurance not only explains the United States' overprescription of opioids and lack of access to interdisciplinary pain management programs, but also speaks to the overutilization of interventional techniques and spinal surgery.[27] In an American health care system that seems fiscally unsustainable,[28] the cost-efficiency of interdisciplinary chronic pain management could potentially save countless billions of dollars every year.[29]

In 2009, the U.S. Veterans Health Administration released its Directive on Pain Management,[30] which included a stepped care model. These steps include tertiary interdisciplinary treatment for chronic pain sufferers, with specific objectives calling for provision of "an interdisciplinary, multi-modal approach to pain management that emphasizes optimal pain control, improved function, and quality of life" (p. 2). In order to ensure quality as well as accessibility of interdisciplinary pain treatment, the Directive states that each of the 23 Veterans Integrated Service Networks in the United States is expected to have at least one interdisciplinary program accredited by the Committee for Accreditation of Rehabilitation Facilities (CARF) no later than September 30, 2014. However, according to VHA officials, this number has already been far surpassed. It is telling that in their 2009 article in *Pain Medicine,* Dobkin and Boothroyd compared pain treatment initiatives in France, Australia, and the United States Veterans Health Administration (as opposed to the United States as a whole).[31]

One of the most significant differences between chronic pain treatment in the United States versus that provided to citizens of other developed nations concerns the lack of a coherent and consistent pain policy in the United States. As has been elucidated by Giordano and colleagues,[32] the for-profit American pain management system is composed of myriad stakeholders—with the insurance industry perhaps the most dominant of these entities. Tragically, the American system (with the exception of the U.S. Department of Veterans Affairs) functions according to the "business ethic" of cost-containment and profitability, with less concern for human suffering.[33] In examining pain policies in other developed nations, it is evident that efforts are being made to develop national policies that include provisions for interdisciplinary pain care. For example, the French Ministry of Health issued its initial set of regulations regarding the treatment of chronic pain, and initiated a national program for chronic pain treatment in 1998, primarily at the tertiary care level. Since 1998, two revisions of the French national program for chronic pain treatment have been released.[34] In Australia, a group led by the Australian and New Zealand College of Anaesthetists, the national Faculty of Pain Medicine, the Australian Pain Society, and Chronic Pain Australia developed a "National Pain Strategy" in 2010.[35] This 94-page document emphasizes the need for "coordinated interdisciplinary assessment and management involving, at a minimum, physical, psychological, and environmental risk factors in each patient (p. 3), recognizing that interdisciplinary care has the strongest evidence-basis and should accordingly be available at all levels. Similarly, in 2010, a group of pain experts from 15 European nations produced a consensus report on the management of chronic pain[36] that highlighted the need for multidisciplinary approaches. Interestingly, the panel of experts who wrote the report was multidisciplinary, coming from a variety of backgrounds; physicians were well represented on the panel, although attorneys, government officials, health economists, pain patient advocacy group representatives, a pharmaceutical company representative, and others were included. The ability of the European pain community to come together for this project is in stark contrast to the American pain community's tendency to be "territorial," with each stakeholder essentially concerned only with its own agenda.[32] The absence of representatives from private insurance companies from the European panel is telling, considering that private insurance companies have been indicted as contributing to the perpetuation of suboptimal pain care in the United States through their progressive refusal to fund interdisciplinary pain management programs.[37]

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Meanwhile, in the United States, guidelines for interdisciplinary pain care may be produced, yet there is no evidence that the fragmented health care system is compelled to follow them. For example, late in 2011, the Agency for Healthcare Research and Quality released a lengthy and detailed technical brief entitled "Multidisciplinary Pain Programs for Chronic Noncancer Pain"[13] This document reviews the literature on the efficacy of interdisciplinary care, notes that the availability of such programs is increasing in Europe while declining in the United States, and discusses the implications of our current lack of access to these

programs. However, the authors fail to offer any type of solution to the problem regarding access to interdisciplinary care. The only significant effort made to develop a national policy that theoretically included increasing the accessibility of interdisciplinary pain care in the United States was the failed National Pain Care Policy Act. This legislation was originally introduced to the U.S. House of Representatives as HR 1863 in 2003. Among other provisions, it called for the establishment of six regional pain *research* centers. However, the legislation did not address the issue of specifically developing *treatment* centers.[38] Lauded by American pain management academicians,[39] the legislation did not directly address the accessibility issue—although the desire to improved access to interdisciplinary care is evident in the spirit of the bill. Unfortunately, this piece of legislation was not able to gain broad legislative support, and morphed into the National Pain Care Policy Act of 2005 (HR 1020), the National Pain Care Policy Act of 2008 (HR 2994, S 3387), and the National Pain Care Policy Act of 2009 (HR 756, S 660), provisions of which were included in President Obama's Affordable Care Act (ACA). Tragically, while the ACA includes provisions for increased pain research and improved pain education, the law falls short of actually improving access to interdisciplinary chronic pain management for the vast majority of Americans.[40]

Few would question that all developed (and probably also undeveloped) nations need increased numbers of interdisciplinary treatment programs in order to improve access to this strongly evidence-based treatment approach

A 2008 systematic review on the impact of waiting time on health-related quality of life (HRQOL) on chronic pain patients concluded that wait times of 6 months or more prior to admission reduce patients' HRQOL and psychological well-being.[41] While this finding is not necessarily surprising, it is important to note that a number of the individual studies included in the review did *not* identify any deterioration associated with waiting time. Few would question that *all* developed (and probably also undeveloped) nations need increased numbers of interdisciplinary treatment programs in order to improve access to this strongly evidence-based treatment approach. It is apparent from the informally collected data presented in this article that while the rest of the developed world is moving in the direction of improving access to interdisciplinary pain care, only in the uniquely capitalist American health care system (with the exception of the more justice-oriented Veterans Health Administration) does interdisciplinary treatment appear to be "going away." In a system infamous for its gross inefficiency,[42] the most effective and cost-efficient treatment for chronic pain is becoming a mere anachronism. While the rest of the developed world faces a considerable challenge if it is to provide timely access to interdisciplinary pain care, it appears that other nations are at least moving in the right direction. Undoubtedly, American policy makers need to step away from their air of world health care supremacy and recognize that the current system serves to exacerbate the suffering of an already vulnerable chronic pain patient population.

Acknowledgments

I would like to thank the following individuals, among others, for their assistance in collecting the data for this analysis: Mark Ballesteros, Silviu Brill, Marcelo Rivano Fischer, Lorna Fox, Frances James, Michel Lanteri-Minet, Mary Lynch, Bart Morlion, Lone Nikolajsen, Victor Mayoral Rojals, and Kris Vissers.

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Printed in the U.S.A.