International Palliative Care Perspective

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Viewpoint

Towards a common definition of global health

Jeffrey P Koplan, T Christopher Bond, Michael H Merson, K Srinath Reddy, Mario Henry Rodriguez, Nelson K Sewankambo, Judith N Wasserheit, for the Consortium of Universities for Global Health Executive Board*

Global health is fashionable. It provokes a great deal of media, student, and faculty interest, has driven the establishment or restructuring of several academic programmes, is supported by governments as a crucial component of foreign policy,[1] and has become a major philanthropic target. Global health is derived from public health and international health, which, in turn, evolved from hygiene and tropical medicine. However, although

communicable infections, the education of the individual in personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of social machinery which will ensure every individual in the community a standard of living adequate for the maintenance of health; so organizing these benefits in such a fashion as to enable every citizen to realize his birthright and longevity."

Lancet 2009; 373: 1993-95
Published Online
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DOI:10.1016/S0140-6736(09)60332-9
See Editorial page 1919
*Members listed at end of paper
Emory Global Health Institute

	Global health
Geographical reach	Focuses on issues that directly or indirectly affect health but that can transcend national boundaries
Level of cooperation	Development and implementation of solutions often requires global cooperation
Individuals or populations	Embraces both prevention in populations and clinical care of individuals
Access to health	Health equity among nations and for all people is a major objective
Range of disciplines	Highly interdisciplinary and multidisciplinary within and beyond health sciences

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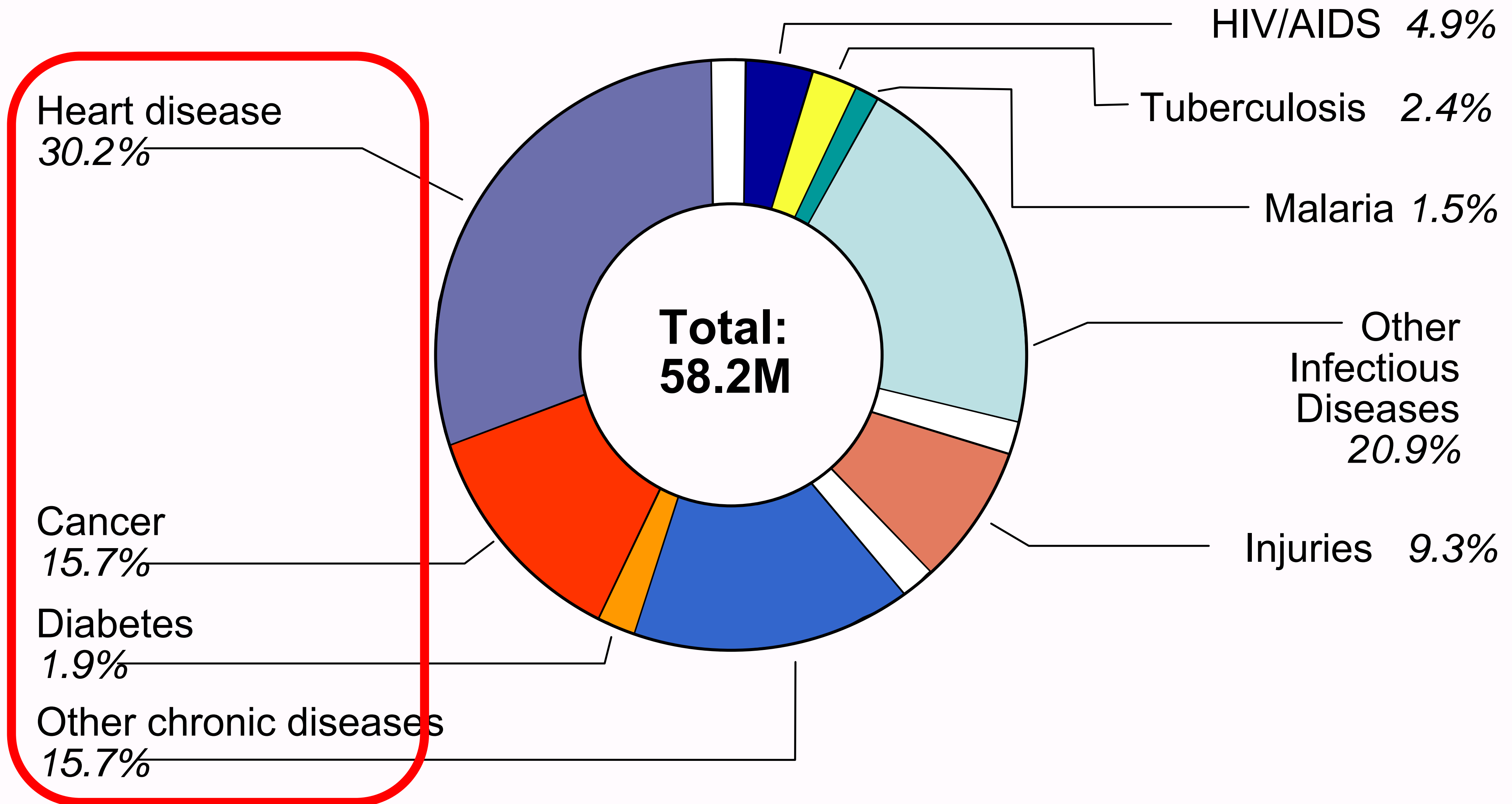
issues that affect the health of the population of a ommunity or country
ent and implementation of solutions does not uire global cooperation
used on prevention programmes for populations
ity within a nation or community is a major
s multidisciplinary approaches, particularly within nces and with social sciences

Table: Comparison of global, international, and public health

Deaths by cause in the world (2005)



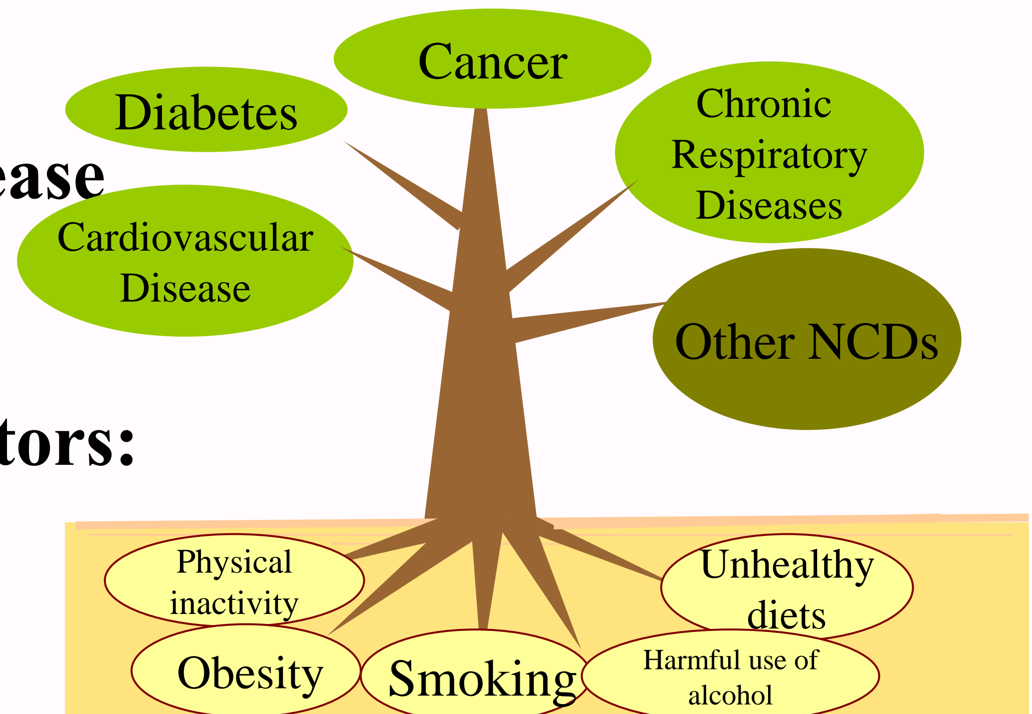
(WHO, Chronic Disease Report, 2005)

Noncommunicable Diseases (NCDs)

- **Responsible for up to 60% of all deaths,**
- **80% are in low- and middle-income countries**

- **Major non-communicable diseases:**
  - **Cardiovascular disease**
  - **Cancer**
  - **Chronic Respiratory disease**
  - **Diabetes**

- **Shared preventable risk factors:**
  - **Tobacco use**
  - **Unhealthy diet**
  - **Physical inactivity**
  - **Harmful use of alcohol**



Noncommunicable diseases (2006-2015)

	2005		2006-2015 (cumulative)		
Geographical regions (WHO classification)	Total deaths (millions)	NCD deaths (millions)	NCD deaths (millions)	Trend: Death from infectious disease	Trend: Death from NCD
Africa	10.8	2.5	28	+6%	+27%
Americas	6.2	4.8	53	-8%	+17%
Eastern Mediterranean	4.3	2.2	25	-10%	+25%
Europe	9.8	8.5	88	+7%	+4%
South-East Asia	14.7	8.0	89	-16%	+21%
Western Pacific	12.4	9.7	105	+1	+20%
	58.2	**35.7**	**388**	**-3%**	**+17%**

WHO projects that over the next 10 years, the largest increase in deaths from cardiovascular disease, cancer, respiratory disease and diabetes will occur in low- and middle-income countries.

(WHO, Chronic Disease Report, 2005)

United Nations General Assembly on non-communicable diseases (NCD)

- Non-communicable Disease (NCD) Summit involving Heads of State, in September 2011, to address the threat posed by NCDs to low- & middle-income countries (LMICs).

- World Heart Federation
- International Diabetes Federation (IDF)
- International Union Against Cancer (UICC)
- the International Union Against Tuberculosis and Lung Disease

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World Health Organization

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Medicines

WHO > Programmes and projects > Medicines > New UN report confirms ongoing lack of access to essential medicines

New UN report confirms ongoing lack of access to essential medicines

The UN report *Strengthening the Global Partnership for Development in a Time of Crisis* highlights the existence of large gaps in the availability of medicines in both the public and private sectors, as well as a wide variation in prices which render essential medicines unaffordable to poor people.

Launched on September 16th as the second report of the MDG Gap Task Force, the report describes progress towards achieving MDG 8 (Develop a global partnership for development) and its related targets in the areas of essential medicines, official development assistance, trade, external debt and technology.

MDG 8, Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential medicines in developing countries was measured using nine indicators for measuring access to medicines using data collected by WHO and its partners. The report found that in the public sector, generic medicines are only available in 38.1% of facilities, and on average cost 250% more than the international reference price. In the private sector, those same medicines are available in 63.3% of facilities, but cost on average about 610% more than the international reference price. High prices often render medicines unaffordable, with common treatment regimens costing a low-paid government worker several days' wages. The cost of treatment for chronic diseases is particularly unaffordable because of the need for lifelong treatment which is less amenable to short-term financial coping strategies.

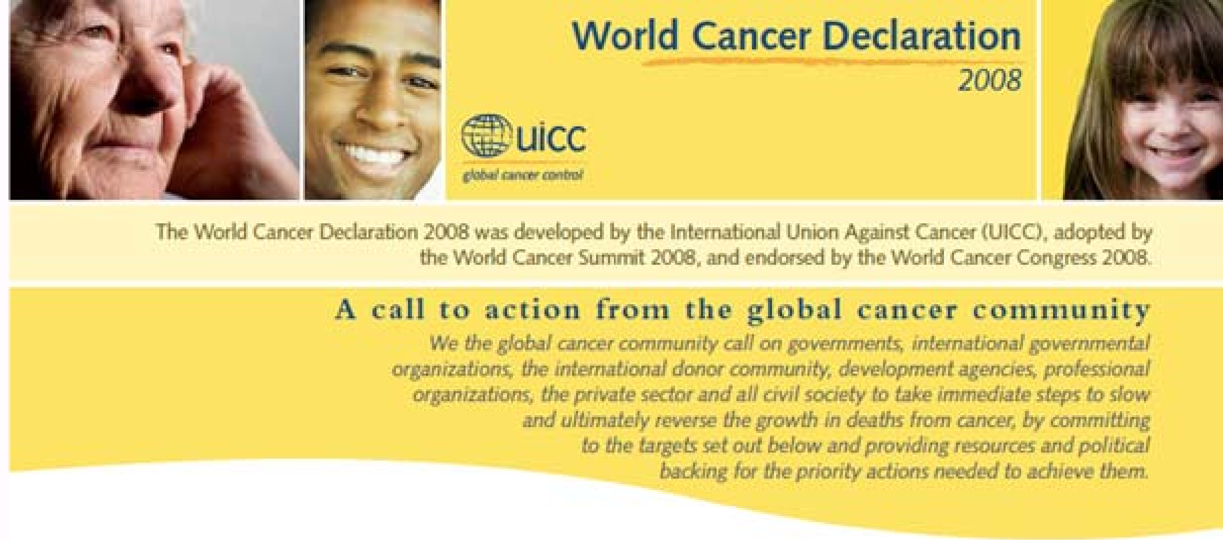
UN - MDG Gap Task Force report 2009
Arabic [pdf 1.60Mb] | Chinese [pdf 2.71Mb] | English [pdf 1.67Mb] | French [pdf 2.47Mb] | Russian [pdf 1.87Mb] | Spanish [pdf 2.46Mb]

UN - MDG Gap Task Force report 2008
Arabic [pdf 1.56Mb] | Chinese [pdf 2.02Mb] | English [pdf 1.67Mb] | French [pdf 1.42Mb] | Russian [pdf 1.45Mb] | Spanish [pdf 1.56Mb]

MDG 8, Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential medicines in developing countries.

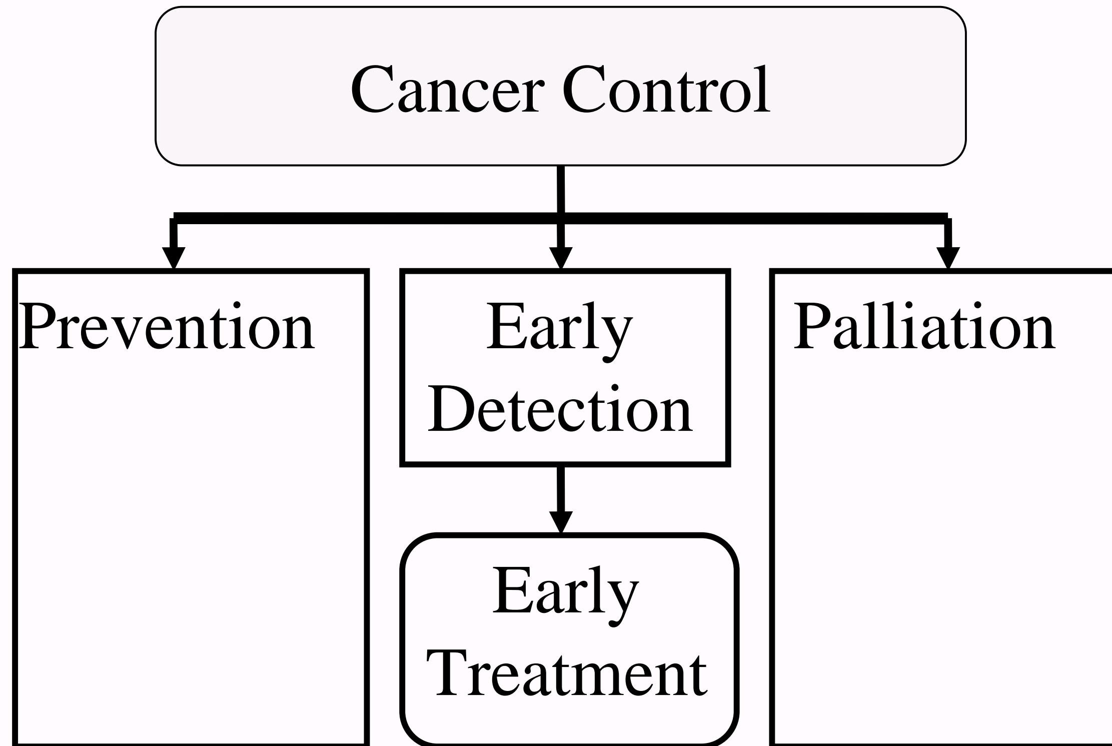
Public:
38% availability of generics
250% of Int reference price

Private:
63% availability of generics
610% of Int reference price



2020 Targets

- **Measurement**
- **Sustainable delivery systems**
- **Tobacco, obesity, alcohol**
- **Vaccination (HBV, HPV)**
- **Dispel myths about cancer**
- **Screening & early detection**
- ***Effective pain control***
- **Training opportunities**
- **Reduce health emigration**
- **Improve cancer survival for all.**

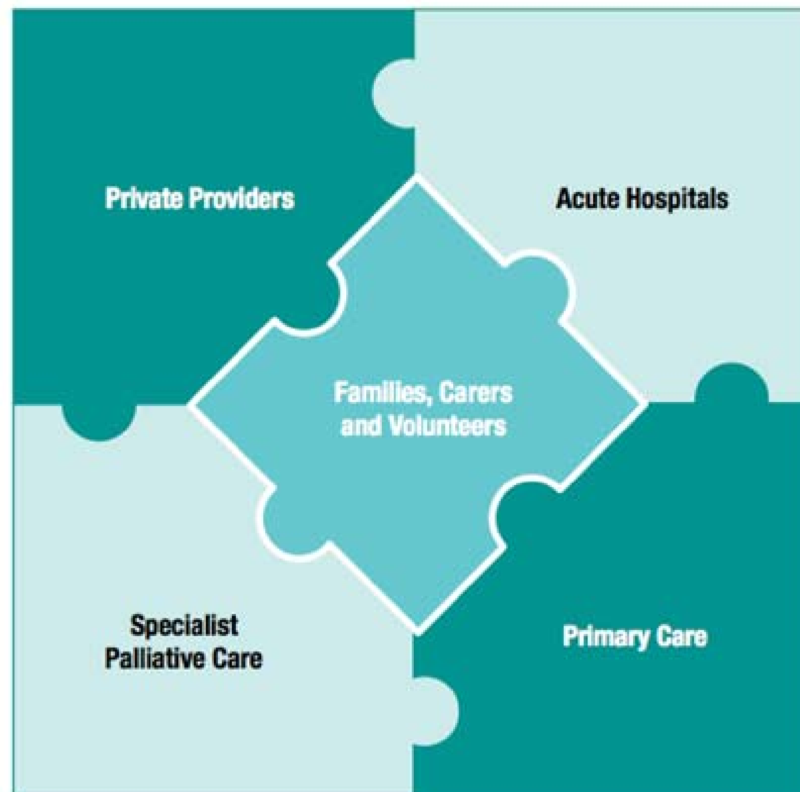

Cancer Control
Prevention
Early Detection
Palliation
Early Treatment

Australian Government

Department of Health and Ageing

Supporting Australians to Live Well at the End of Life

National Palliative Care Strategy 2010



Supporting Australians to Live Well at the End of Life

National Palliative Care Strategy 2010

goal area	number	goal
Awareness and Understanding	Goal 1	To significantly improve the appreciation of dying and death as a normal part of the life continuum.
	Goal 2	To enhance community and professional awareness of the scope of, and benefits of timely and appropriate access to, palliative care services.
Appropriateness and Effectiveness	Goal 3	Appropriate and effective palliative care is available to all Australians based on need.
Leadership and Governance	Goal 4	To support the collaborative, proactive, effective governance of national palliative care strategies, resources and approaches.
Capacity and Capability	Goal 5	To build and enhance the capacity of all relevant sectors in health and human services to provide quality palliative care.

Mrs MB

- 86 year old woman
- Oct: Endometrial cancer with bone mets
- 3 weeks later
  - ?small stroke --> fall --> broken hip.

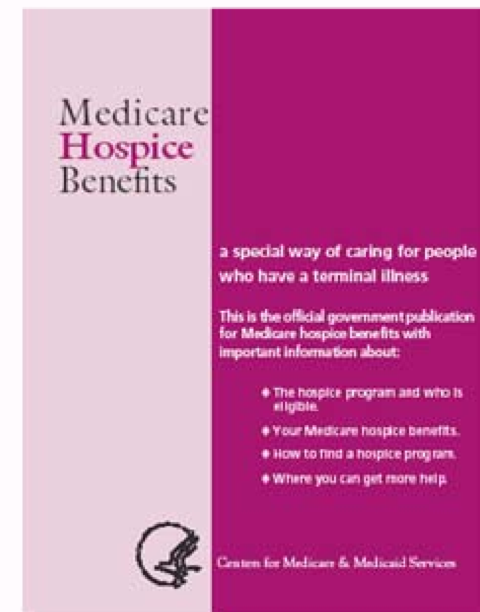
  - Repair?
  - Keep comfortable with opioids?

  - What is the goal of care?

Election Statement

- **Identification of the hospice**
- **Acknowledgement of full understanding of**
  - ***palliative* rather than**

    ***curative* nature of hospice care.**
- **Waiver of certain Medicare Services**
- **Effective date of election**
- **Individual's signature**



"Single payer, rationing"

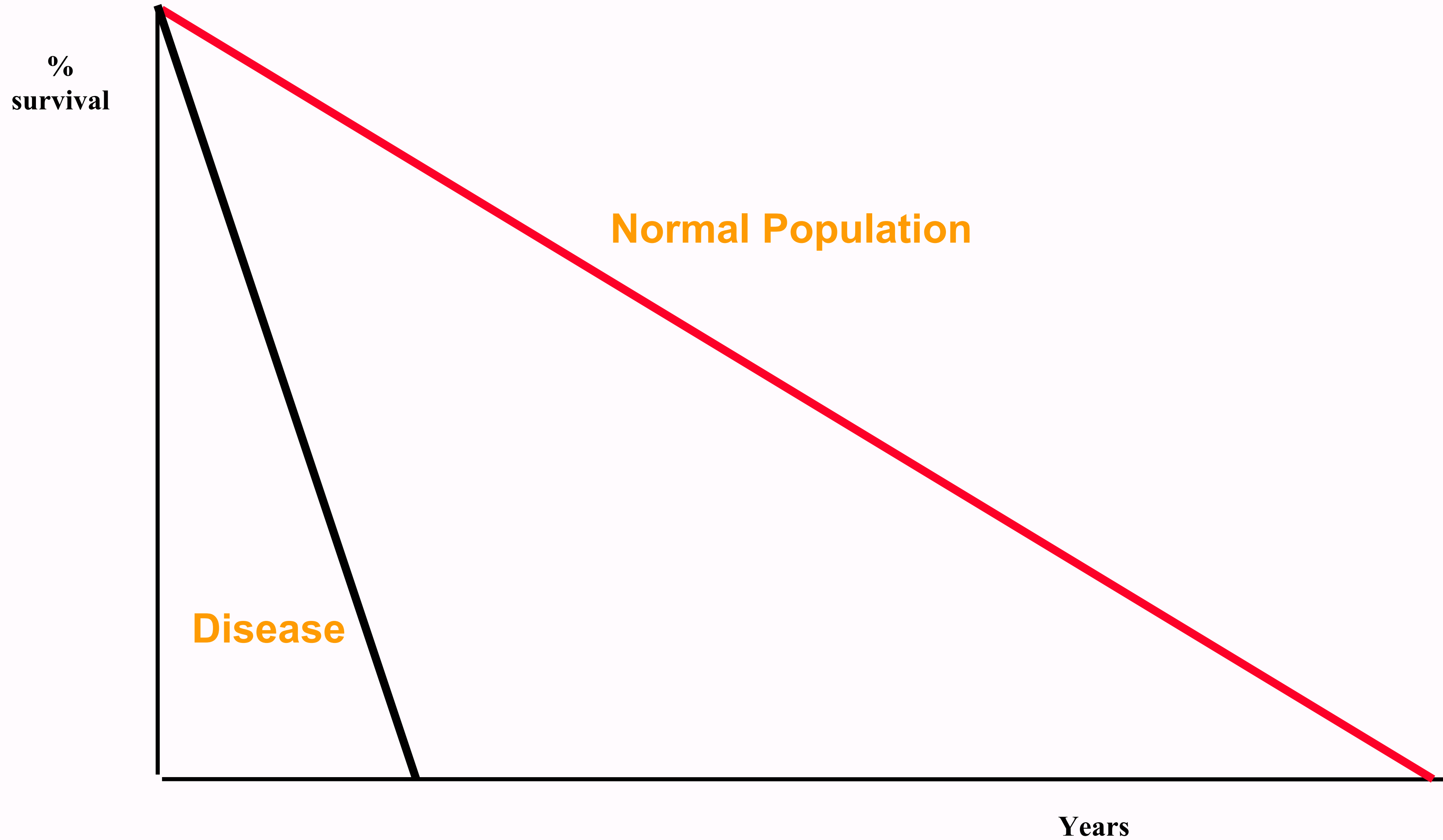
Intentions of Treatment

Palliative

vs

Curative

Survival Curve: Disease



The scope of the problem…

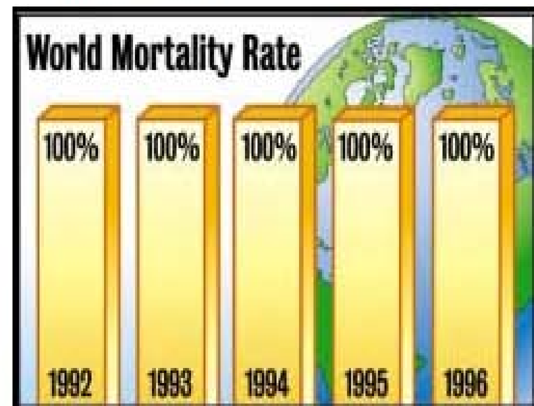
INTERNATIONAL

World Death Rate Holding Steady At 100 Percent

JANUARY 22, 1997 | ISSUE 31-02

GENEVA, SWITZERLAND—World Health Organization officials expressed disappointment Monday at the group's finding that, despite the enormous efforts of doctors, rescue workers and other medical professionals worldwide, the global death rate remains constant at 100 percent.

ENLARGE IMAGE



Death rates since 1992

Death, a metabolic affliction causing total shutdown of all life functions, has long been considered humanity's number one health concern. Responsible for 100 percent of all recorded fatalities worldwide, the condition has no cure.

"I was really hoping, what with all those new radiology treatments, rescue helicopters, aerobics TV shows and what have you, that we might at least make a dent in it this year," WHO Director General Dr. Gernst Bladt said. "Unfortunately, it would appear that the death rate remains constant and total, as it has inviolably since the dawn of time."

Many are suggesting that the high mortality rate represents a massive failure on the part of the planet's health care workers.

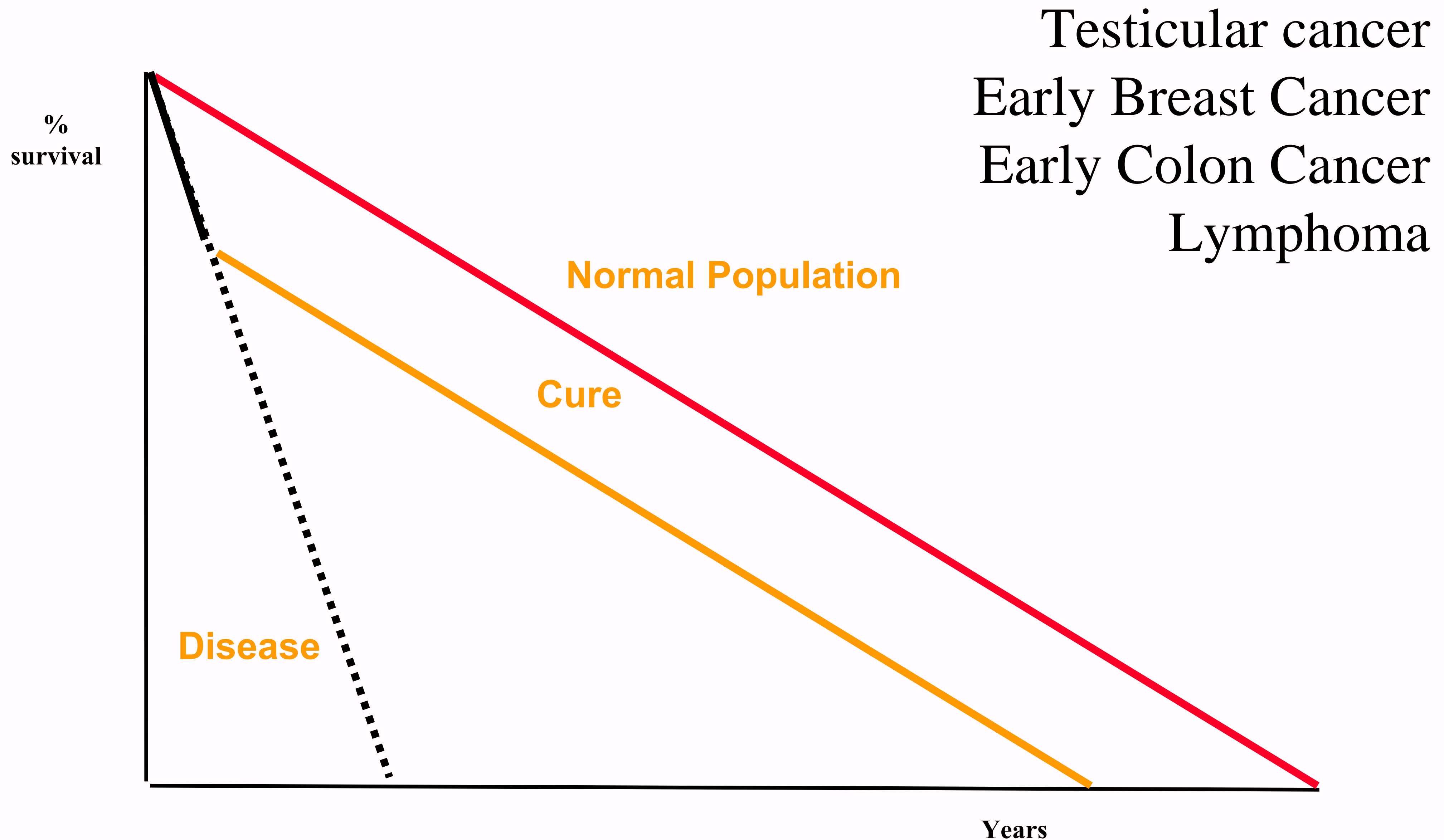
"The inability of doctors and scientists to adequately address this issue of death is nothing less than a scandal," concerned parent Marcia Gretto said. "Do you have any idea what a full-blown case of death looks like? Well, I do, and believe me, it's not pretty. In prolonged cases, total decomposition of the corpse is the result."

"What about the children?" the visibly moved Gretto added.

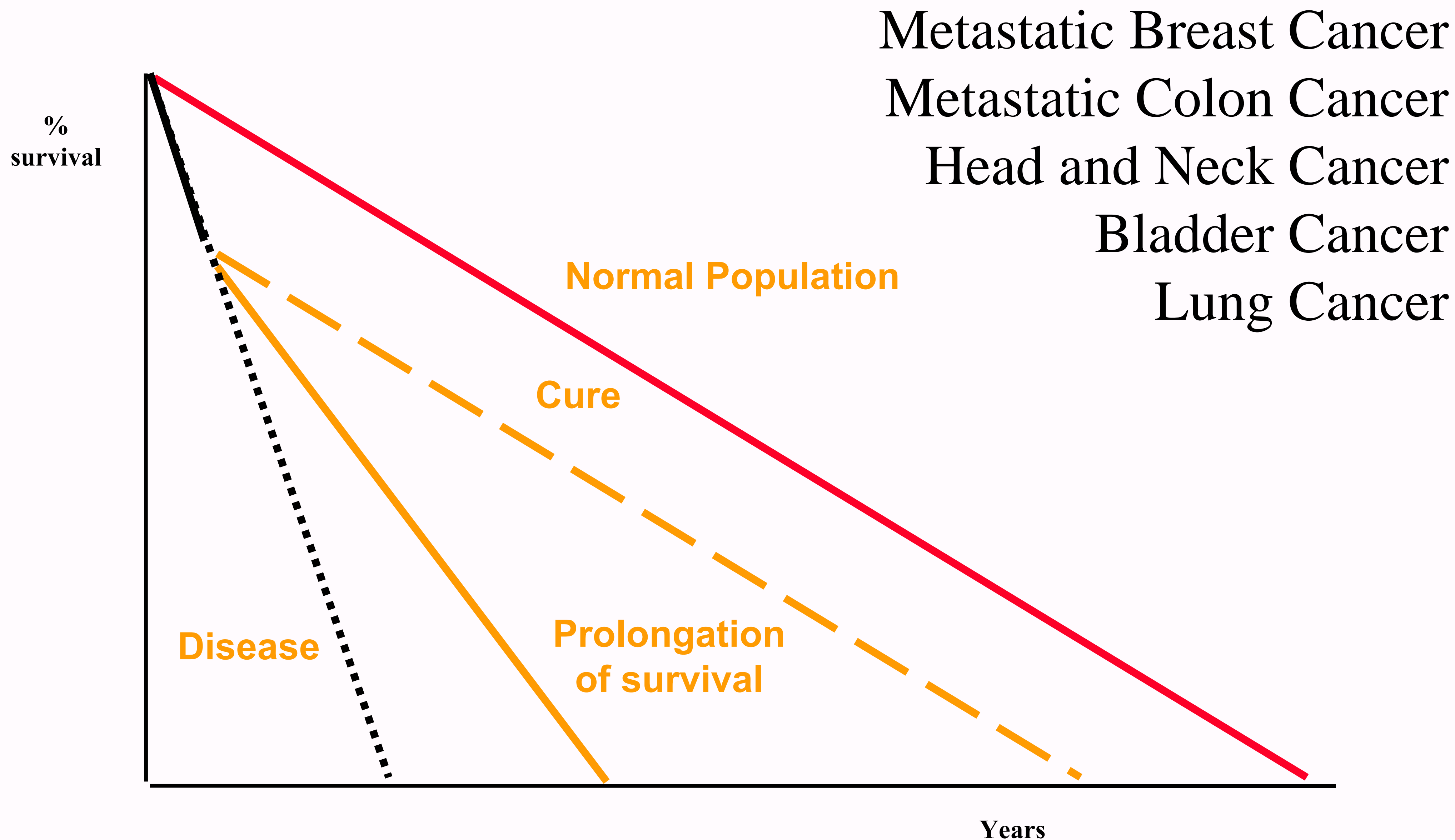
"At this early date, I don't want to start making broad generalizations," Citizens for Safety's Robert Hemmlin said, "but it is beginning to seem possible that birth—as well as the subsequent life cycle that follows it—may be a serious safety risk for all those involved."

Death, experts say, affects not only the dead, but the non-dead as well.

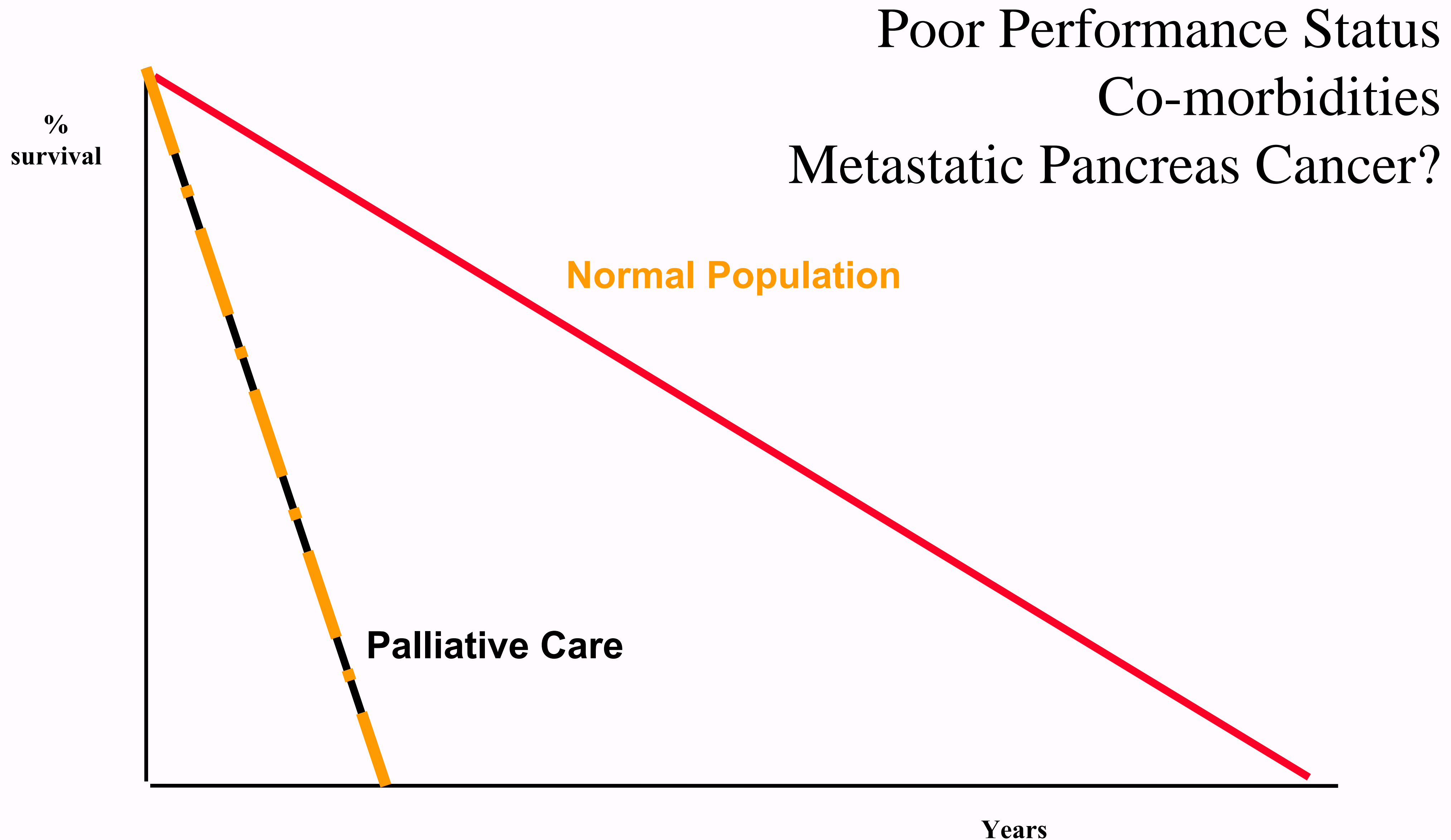
Survival Curve: Cure



Survival Curve: Prolongation of Survival



Survival Curve: Palliative Care



Mrs MB

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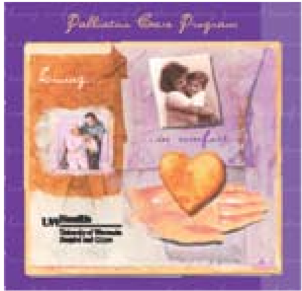
  - ?small stroke --> fall --> broken hip.

  - Repair?
  - Keep comfortable with opioids?

  - How do we provide palliative care?

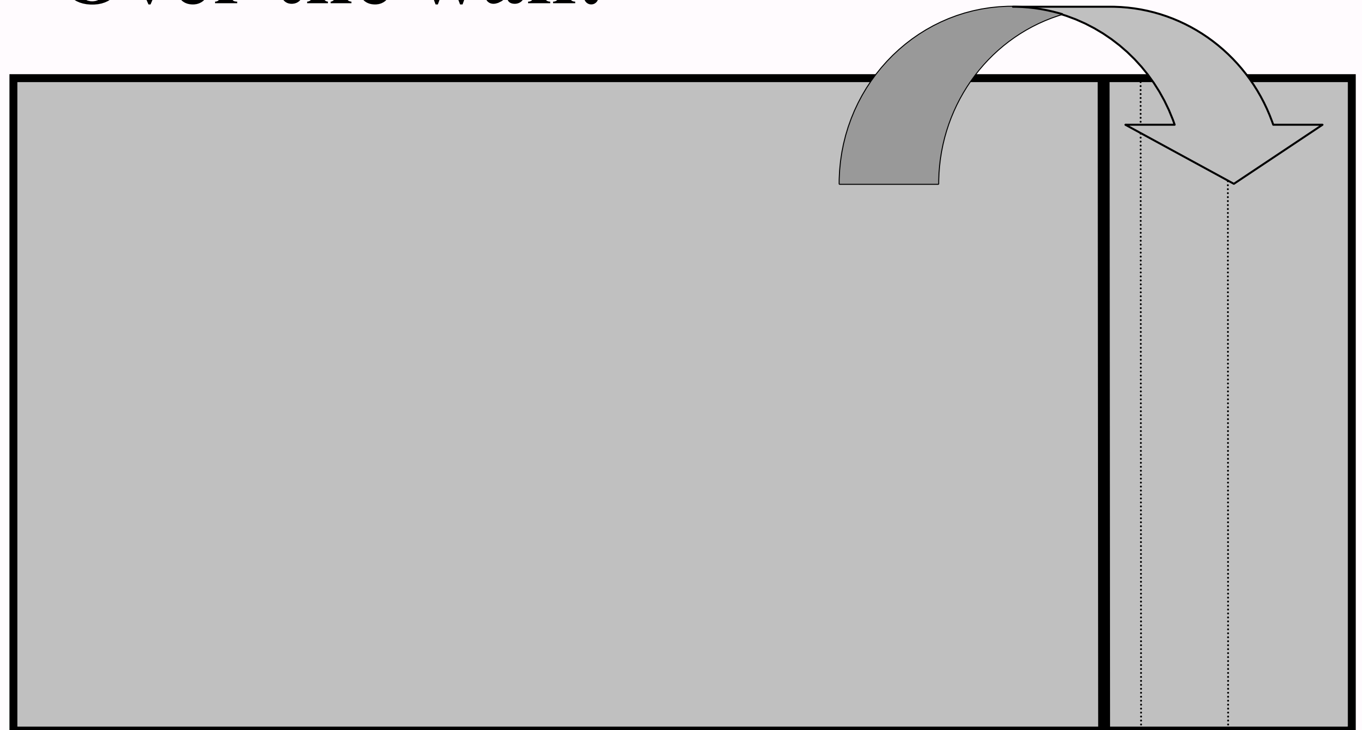
Path of Care with Repair

- without Hospice?
  - Surgery
  - Rehab: nursing home Medicare if progress
  - Consider Hospice later
- with Hospice?
  - Surgery
  - Hospital $600/day for 5 days includes OR
  - MD billing separate
  - Rehab: Goal not palliative?
  - Medicare: double dipping
  - Hospice benefit questionable



Palliative Care now

Over the wall!



Standard Medical Care **Hospice**

Economist Intelligence Unit | The Economist

The quality of death
Ranking end-of-life care across the world

A report from the Economist Intelligence Unit

Commissioned by

Overall score

Rank	Country	Score
1	UK	7.9
2	Australia	7.9
3	New Zealand	7.7
4	Ireland	6.8
5	Belgium	6.8
6	Austria	6.6
7	Netherlands	6.3
8	Germany	6.2
=9	Canada	6.2
=9	US	6.2
11	Hungary	6.1
12	France	6.1
13	Norway	6.0
14	Taiwan	6.0
15	Poland	6.0
16	Sweden	5.9
17	Luxembourg	5.7
18	Singapore	5.5
19	Switzerland	5.4
20	Hong Kong	5.3
21	Czech Republic	5.2
22	Denmark	5.1

Economist Intelligence Unit | The Economist

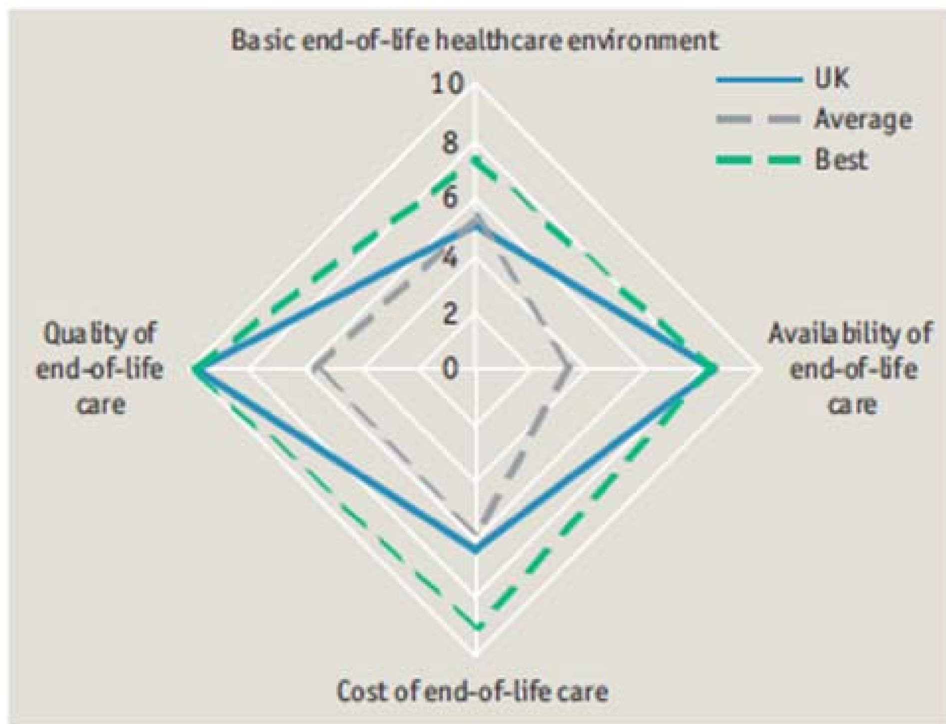
The quality of death

Ranking end-of-life care across the world

A report from the Economist Intelligence Unit

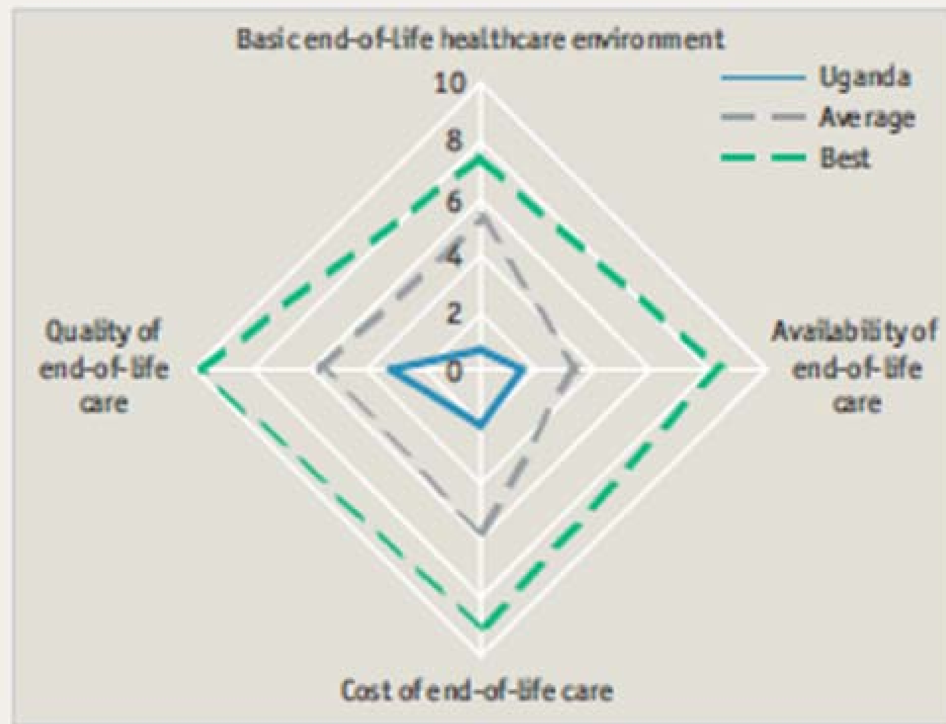
Commissioned by

UK	Score/10	Rank/40
Overall score	7.9	1
Basic end-of-life healthcare environment	5.0	28
Availability of end-of-life care	8.4	1
Cost of end-of-life care	6.3	18
Quality of end-of-life care	9.8	1



Source: Economist Intelligence Unit.

Uganda	Score/10	Rank/40
Overall score	2.1	39
Basic end-of-life healthcare environment	0.7	40
Availability of end-of-life care	1.5	34
Cost of end-of-life care	2.0	36
Quality of end-of-life care	3.1	36



Source: Economist Intelligence Unit.

Basic end-of-life healthcare environment (20% weight

Rank	Country	Score
1	Switzerland	7.
2	Japan	7.
3	France	7.3
4	Netherlands	7.3
5	Belgium	7.2
6	Germany	7.0
7	Luxembourg	7.0
8	Austria	6.8
9	US	6.6
10	Czech Republic	6.2
11	Iceland	6.2
12	Norway	6.1
13	Greece	6.1
14	Hungary	5.8
15	Taiwan	5.8
16	Slovakia	5.7
17	Ireland	5.7
18	Finland	5.7
19	Australia	5.6
=20	Canada	5.6
=20	South Korea	5.6
22	Denmark	5.6
23	Sweden	5.4
24	Italy	5.4
=25	Poland	5.3
=25	Spain	5.3
27	Portugal	5.1
=28	New Zealand	5.0
=28	UK	5.0
30	Singapore	4.9
31	Hong Kong	4.8
32	Mexico	4.1
33	Turkey	3.5
34	Russia	3.4
35	Brazil	3.4
36	China	2.8
37	Malaysia	2.4
38	South Africa	2.3
39	India	1.3
40	Uganda	0.7

Source: Economist Intelligence Unit.

Availability of end-of-life care (25% weighting)

Rank	Country	Score
1	UK	8.4
2	New Zealand	7.2
3	Australia	6.9
4	Switzerland	5.8
5	Belgium	5.2
6	Austria	5.1
7	Ireland	5.0
8	US	5.0
9	Canada	4.9
10	Poland	4.8
11	Sweden	4.5
12	Luxembourg	4.4
13	South Africa	4.3
14	Italy	4.2
15	Netherlands	3.9
16	Singapore	3.7
17	Iceland	3.5
18	Germany	3.4
19	Taiwan	3.2
20	Norway	3.2
21	Turkey	3.2
22	Malaysia	3.0
23	France	3.0
24	Hong Kong	2.4
25	Mexico	2.4
26	Spain	2.3
27	Greece	2.3
28	Japan	2.2
29	Hungary	2.2
30	South Korea	2.1
31	Denmark	2.0
32	Finland	1.9
33	Czech Republic	1.5
34	Uganda	1.5
35	India	1.3
36	Brazil	1.2
37	Slovakia	1.2
38	Portugal	0.9
39	Russia	0.7
40	China	0.6

Source: Economist Intelligence Unit.

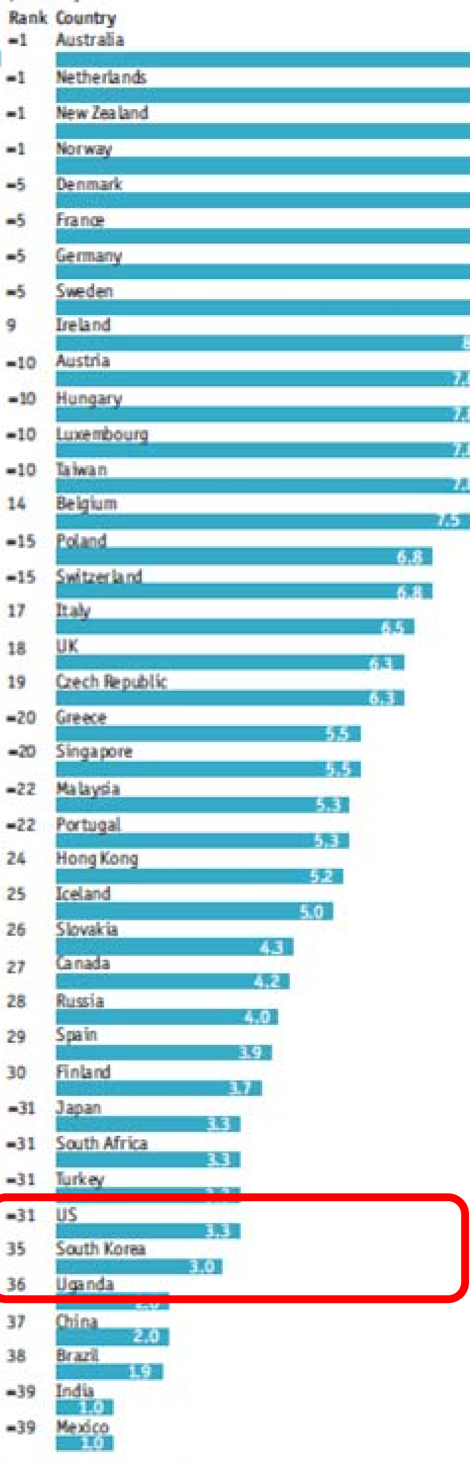
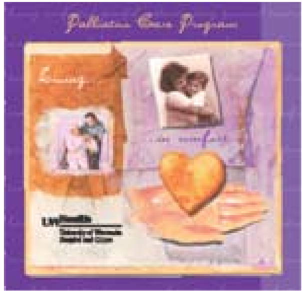


Figure 7: Public awareness of end-of-life care

Highest ranking (excellent) — Lowest ranking (poor)

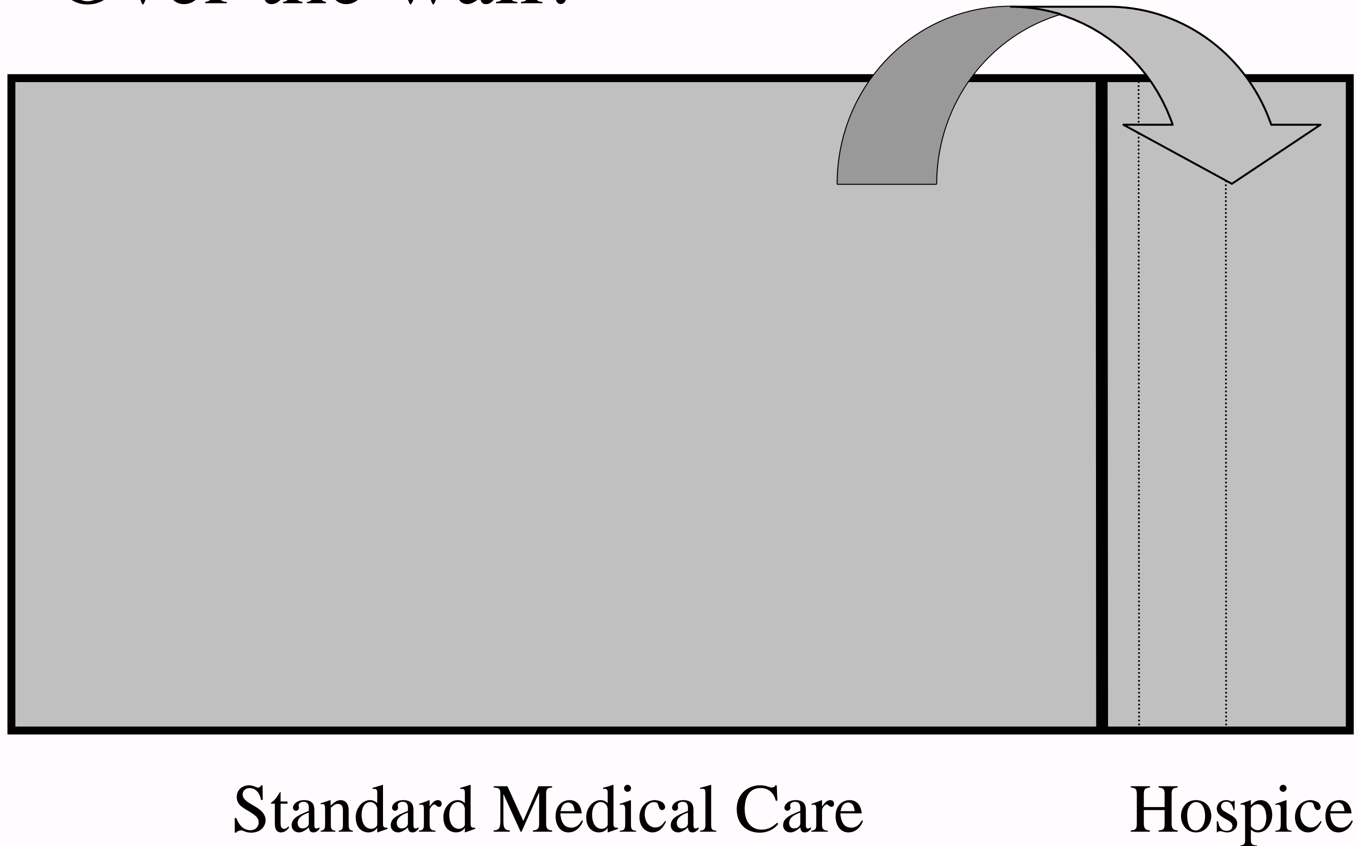
5	4	3	2	1
Belgium	Australia	Canada	Brazil	China
Ireland	Austria	Czech Republic	Finland	
UK	France	Denmark	Greece	
	Hungary	Germany	India	
	Japan	Hong Kong	Italy	
	South Korea	Iceland	Luxembourg	
	Netherlands	Malaysia	Mexico	
	New Zealand	Poland	Portugal	
	Norway	Singapore	Russia	
	Sweden	Slovakia	Switzerland	
	Taiwan	South Africa	Turkey	
	Uganda	Spain		
		US		

Source: Economist Intelligence Unit ranking, based on input from Ministries of Health, country palliative care advocacy organisations.



Palliative Care now

Over the wall!



Health care may be the most entrenched, change-averse industry in the United States. The innovations that will eventually turn it around are ready, in some cases – but they can't find backers.

Will Disruptive Innovations **Cure Health Care?**

by Clayton M. Christensen, Richard Bohmer, and John Kenagy

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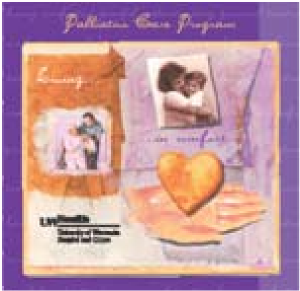


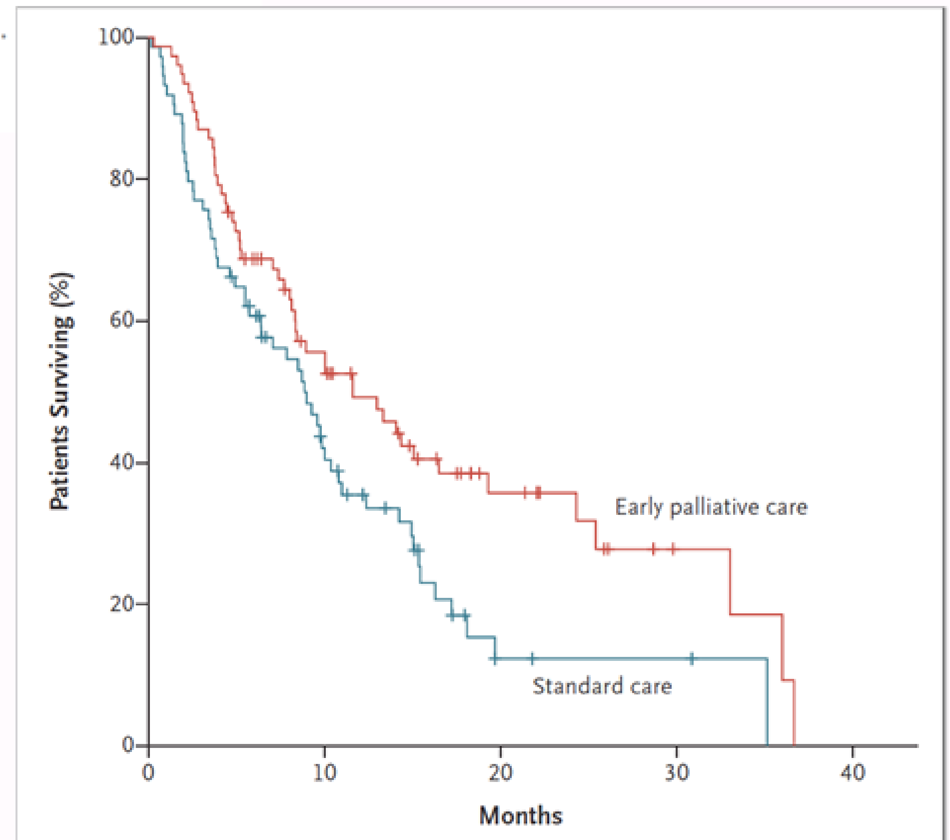
Palliative Care

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

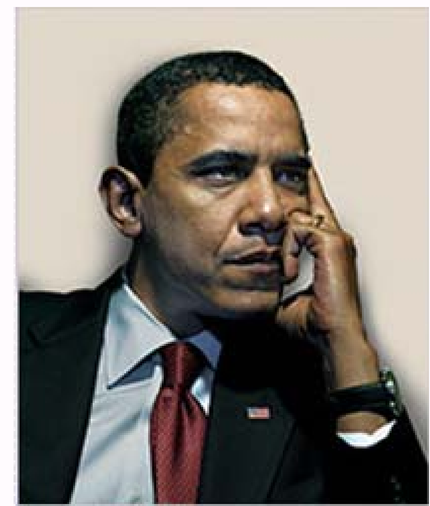
Jennifer S. Temel, M.D., Joseph A. Greer, Ph.D., Alona Muzikansky, M.A., Emily R. Gallagher, R.N., Sonal Admane, M.B., B.S., M.P.H., Vicki A. Jackson, M.D., M.P.H., Constance M. Dahlin, A.P.N., Craig D. Blinderman, M.D., Juliet Jacobsen, M.D., William F. Pirl, M.D., M.P.H., J. Andrew Billings, M.D., and Thomas J. Lynch, M.D.



Mrs MB

- 86 year old woman
- Oct: Endometrial cancer with bone mets
- 3 weeks later
  - –?small stroke --> fall --> broken hip.
  - –Repair
- Died two weeks later:

Obama, NY Times April 2009



Now, I actually think that the tougher issue around medical care — it's a related one — is what you do around things like end-of-life care —

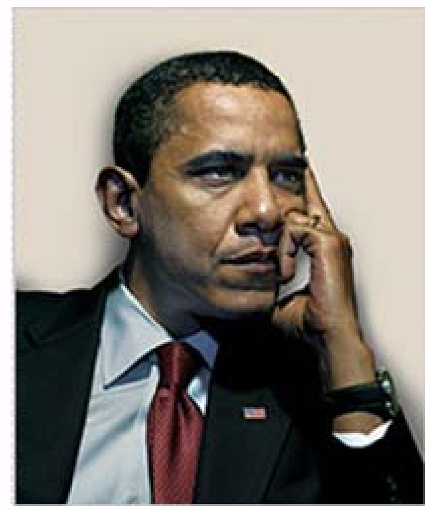
LEONHARDT: Yes, where it's $20,000 for an extra week of life.

Exactly. And I just recently went through this…..

So now she's in the hospital, and the doctor says, Look, you've got about — maybe you have 3 months, maybe …..6 months, maybe you have 9 months to live. Because of the weakness of your heart, if you have an operation on your hip there are certain risks that — you know, your heart can't take it. On the other hand, if you just sit there with your hip like this, you're just going to waste away & your quality of life will be terrible.

And she elected to get the hip replacement and was fine for about two weeks after the hip replacement, and then suddenly just — you know, things fell apart

Obama, NY Times April 2009: 2



LEONHARDT: So how do you — how do we deal with it?

Well, I think that there is going to have to be a conversation that is guided by doctors, scientists, ethicists.

And then there is going to have to be a very difficult democratic conversation that takes place. It is very difficult to imagine the country making those decisions just through the normal political channels.

And that's part of why you have to have some independent group that can give you guidance. It's not determinative, but I think has to be able to give you some guidance. And that's part of what I suspect you'll see emerging out of the various health care conversations that are taking place on the Hill right now.

COMMUNITY

Oprah and Australia's 'socialist' health care

SUSAN BIGGAR | DECEMBER 16, 2010

Oprah is here. With a US TV audience of seven million expected to tune in to discover our beauty rich and rare, what will Australia showcase? Should we highlight this country's external magnificence? Or could now be the time to really show off by exposing the US to our healthcare system?

Thanks to the strength of the Aussie dollar, many tourist operators are doing it tough; all they want for Christmas is for Oprah's visit to usher in a flood of big-spending Midwesterners. But possibly the greatest Christmas present we could give America would be a broken leg or burst appendix for Oprah.

If she — friend of President Obama and host of the highest-rated talk show in US history — were to find herself a customer on the doorstep of Australia's excellent and equitable healthcare system, America's best-known mouth might go home peddling a message that could change the foundations of her society.

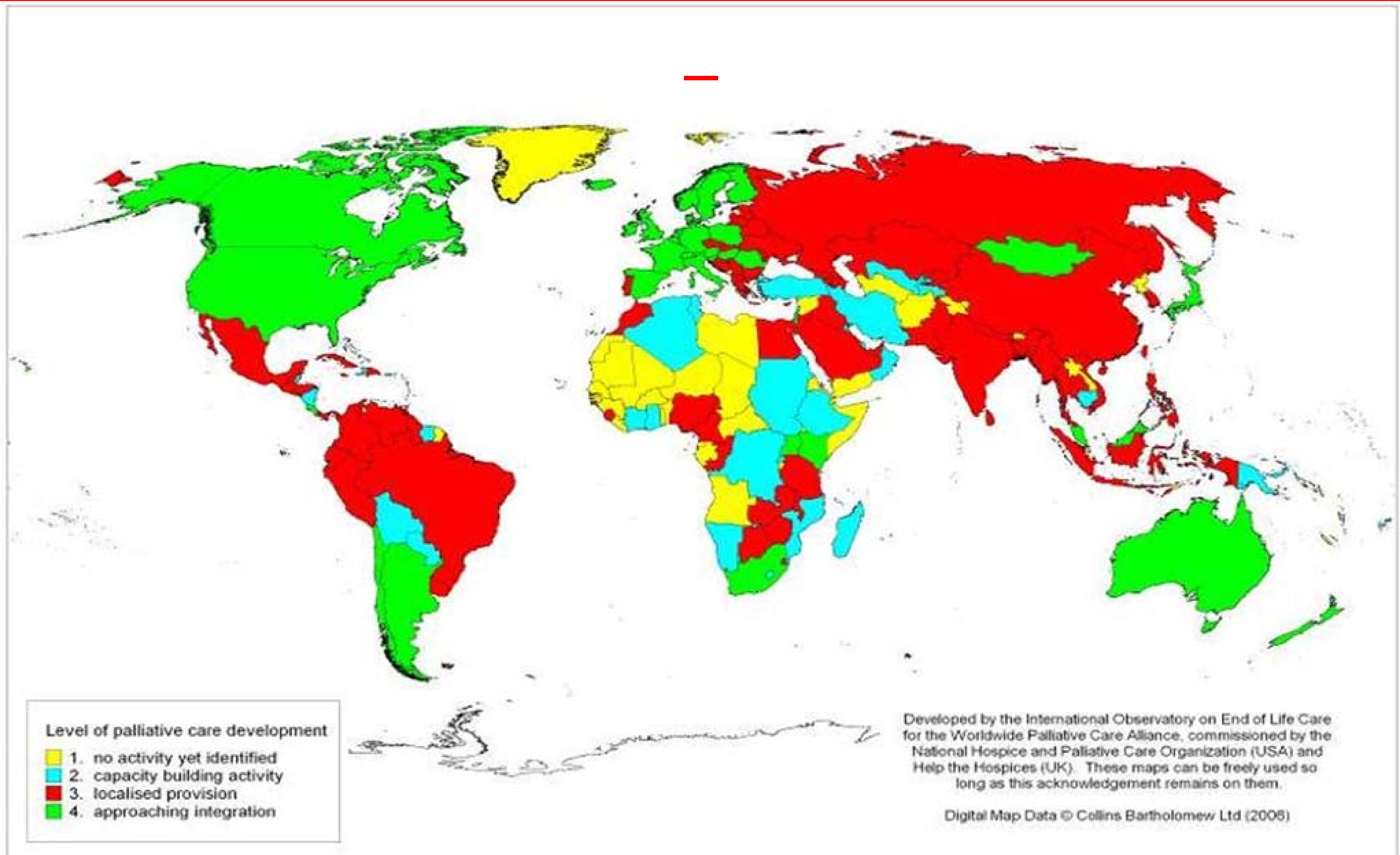
As an American, though now permanently resident in Australia, I can't imagine a better gift for my compatriots.

THE UNITED STATES PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF

Global Health Initiative

Through the Global Health Initiative (GHI) the United States will invest $63 billion over six years to help partner countries improve health outcomes through strengthened health systems – with a particular focus on improving the health of women, newborns and children through programs including infectious disease, nutrition, maternal and child health, and safe water. The GHI aims to maximize the sustainable health impact the United States achieves for every dollar invested. The GHI will deliver on that commitment through a business model based on: implementing a woman- and girl-centered approach; increasing impact and efficiency through strategic coordination and integration; strengthening and leveraging key partnerships, multilateral organizations, and private contributions; encouraging country ownership and investing in country-led plans; improving metrics, monitoring and evaluation; and promoting research and innovation. Through this model the GHI will build on the Bush Administration's successful record in global health, and take these remarkable achievements to the next level by further accelerating progress and investing in sustainable health delivery systems for the future.

World map: all groups (countries n=234)



Drugs

Codeine
Fentanyl
Hydromorphone
Methadone
Morphine
Oxycodone
Pethidine
Morphine Equivalence

What is Morphine Equivalence?

Regions

World
South America
Central America
North America
All of Africa
Central Africa
Northern Africa
Southern Africa
Eastern Asia
Southern Asia
Asia/Pacific region
Central Asia
Middle East
Northern Asia
Northern Europe
Western Europe
Southern Europe

mg/Capita

> 10	
1 - 10	
0.1 - 1	
0.01 - 0.1	
< 0.01	
No data	

Important Legend Note

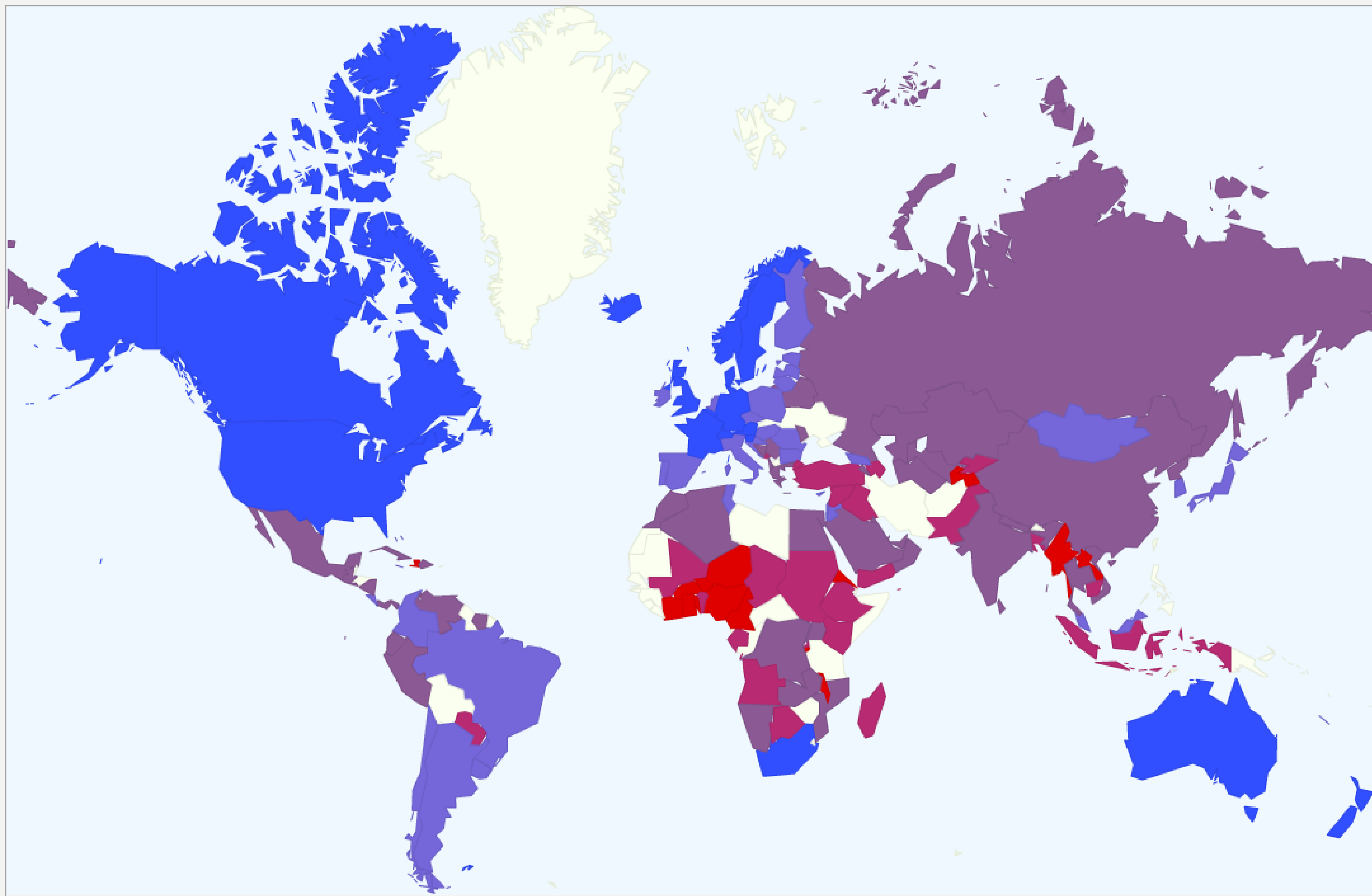


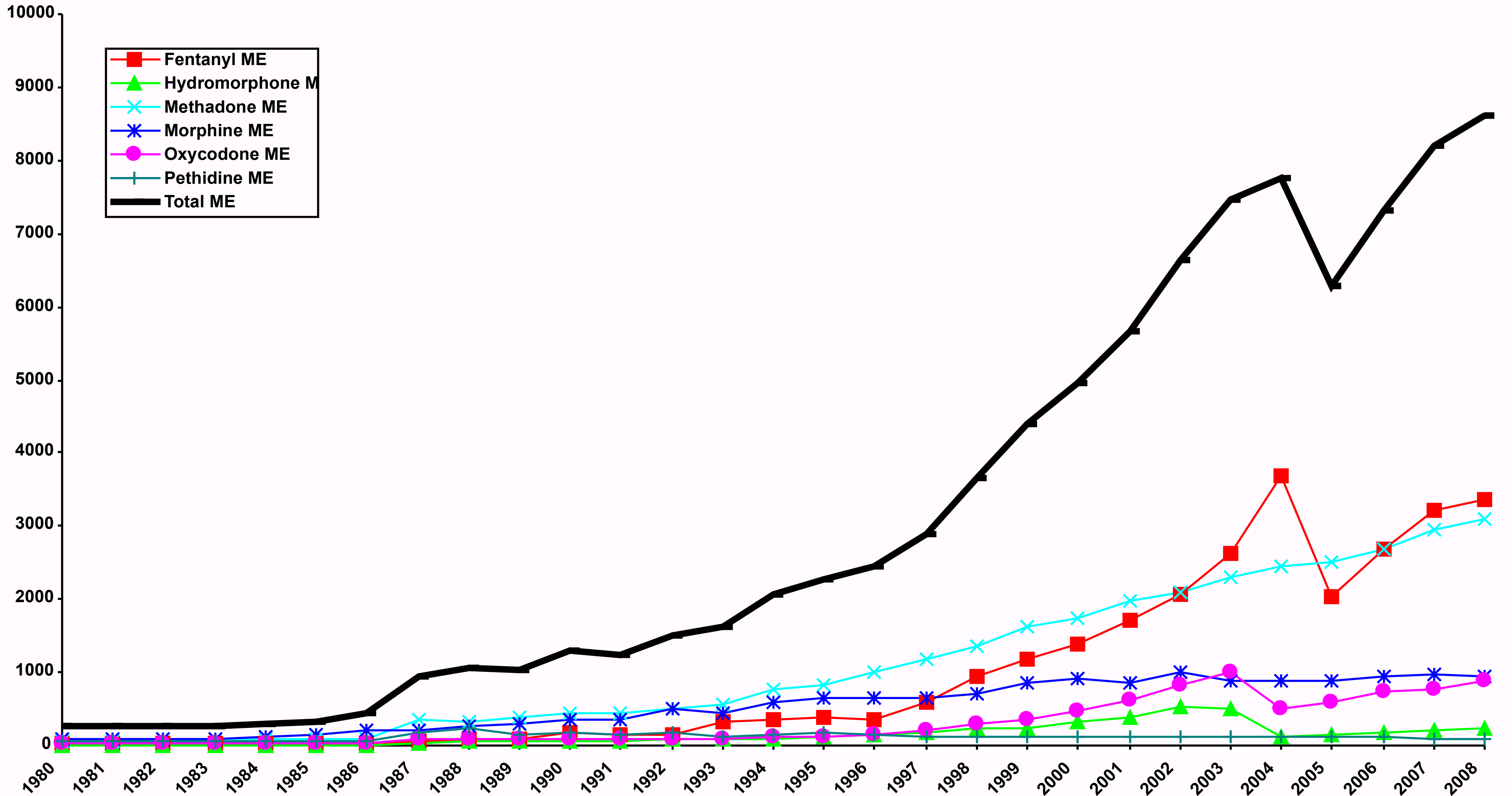
Figure 10: Availability of pain killers (morphine and morphine equivalents)

Highest ranking (excellent) → Lowest ranking (poor)

5	4	3	2	1
Australia	China	Austria	Czech Republic	India
Canada	Germany	Belgium	Greece	
Denmark	Hong Kong	Brazil	Mexico	
Luxembourg	Hungary	Finland	Russia	
Netherlands	Ireland	France	Slovakia	
New Zealand	Japan	Iceland	South Korea	
Portugal	Poland	Italy	Turkey	
Sweden	Spain	Malaysia	Uganda	
	Taiwan	Norway		
	UK	Singapore		
	US	South Africa		
		Switzerland		

Source: Economist Intelligence Unit ranking based on: Pain Policy Center's comparisons of consumption vs. need, interviews, European Atlas of Palliative Care.

Global Trend 1980 - 2008



Source: International Narcotics Control Board

By: Pain & Policy Studies Group, University of Wisconsin/WHO Collaborating Center, 2010

PPSG

- 1996: Pain and Policy Study Group
  - National
  - International
- Close Ties with INCB
  - Opioid Consumption Data
  - Model Laws: on hold
- WHO Collaborating Center
  - Cancer Control
  - Access to Controlled Medications Program
    - INCB Workshop Estimates; Dec 2009

SINGLE CONVENTION
on
NARCOTIC DRUGS, 1961,

as amended by
the 1972 Protocol Amending the Single Convention
on Narcotic Drugs, 1961

UNITED NATIONS

Establishes a Framework to:

1. Prevent abuse and diversion, *and*
2. Ensure the availability of drugs for medical purposes

SINGLE CONVENTION
on
NARCOTIC DRUGS, 1961,

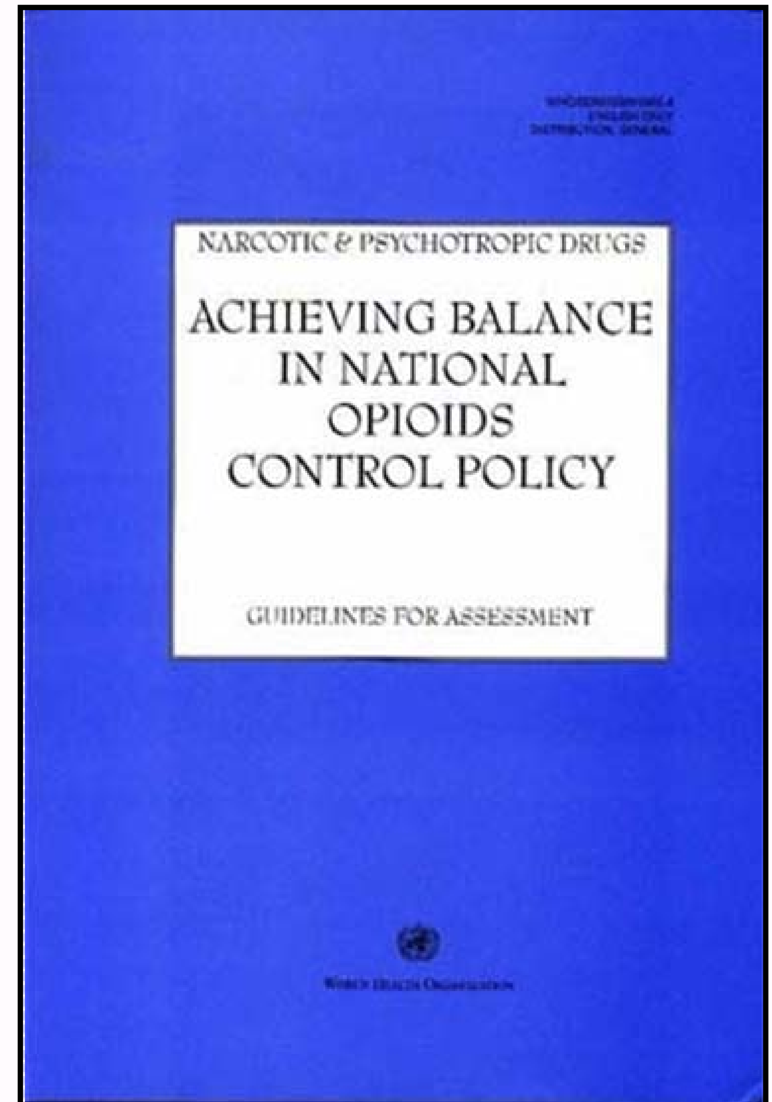
as amended by
the 1972 Protocol Amending the Single Convention
on Narcotic Drugs, 1961

UNITED NATIONS

"the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering… adequate provision must be made to ensure the availability of narcotic drugs for such purposes." (*Preamble*, p. 13)

Achieving Balance in National Opioids Control Policy: Guidelines for Assessment (2000)

- ✓ For governments and health professionals
- ✓ Explains need, rationale and imperative
- ✓ 16 criteria
- ✓ Simplified Checklist
- ✓ 22 Languages



"Balance" is the Fundamental Principle

National policy should establish a drug control system that prevents diversion ***and*** ensures adequate availability for medical use

Drug control measures should not interfere with medical access to opioid

www.painpolicy.wisc.edu

Arabic
Bulgarian
Chinese
English
French
German
Hindi
Indonesian
Italian
Lithuanian
Mongolian

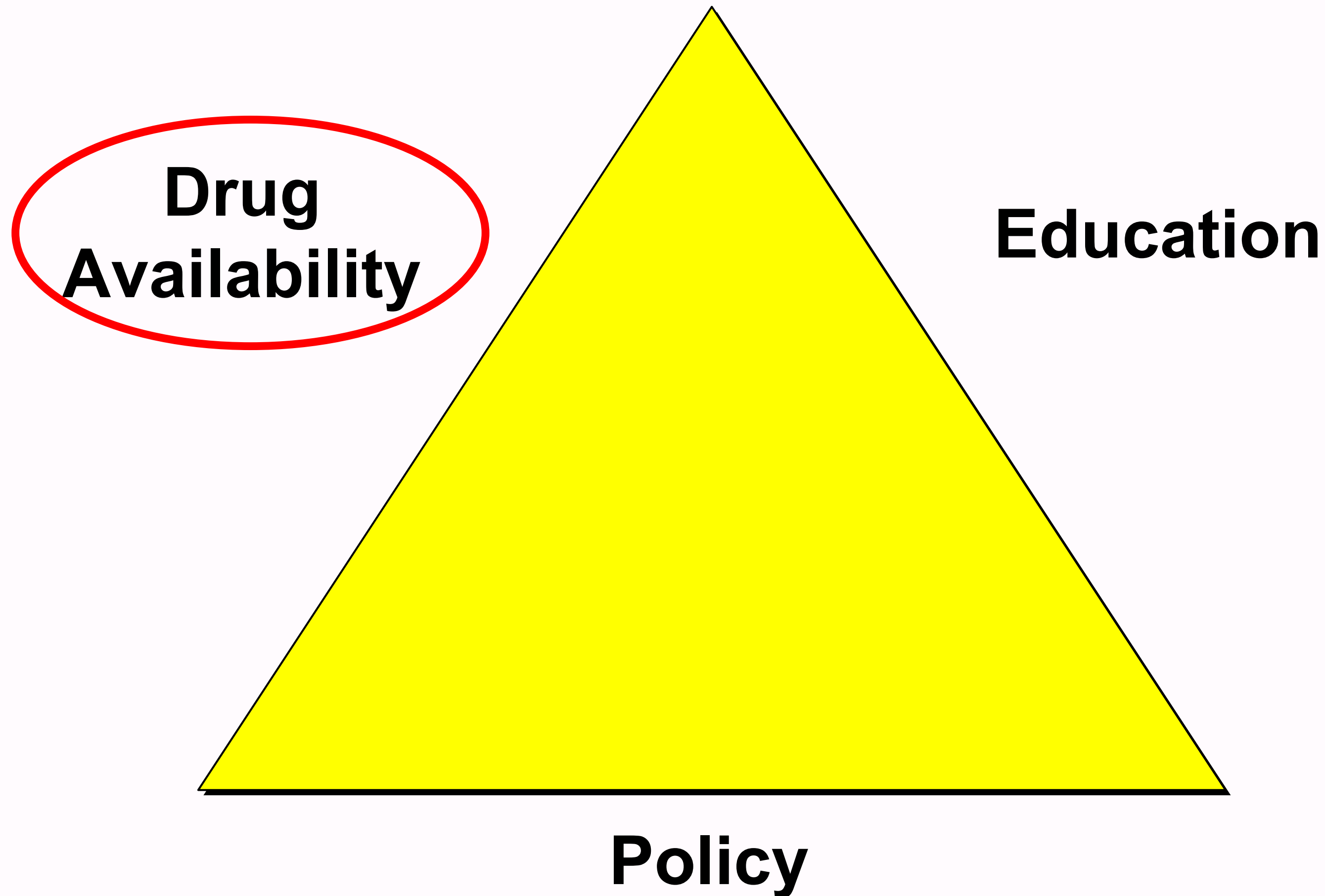
Документ № WHO/EDM/QSM/2000.4
СТАТУС ДОКУМЕНТА: ЗАГАЛЬНИЙ
WORLD HEALTH ORGANIZATION
ВСЕСВІТНЯ ОРГАНІЗАЦІЯ ОХОРОНИ ЗДОРОВ'Я

НАРКОТИЧНІ ТА ПСИХОТРОПНІ ПРЕПАРАТИ
ДОСЯГНЕННЯ ВІДПОВІДНОСТІ НАЦІОНАЛЬНИХ ПОЛІТИК КОНТРОЛЮ ЗА ЗАСТОСУВАННЯМ ОПІОЇДІВ
РЕКОМЕНДАЦІЇ ЩОДО ОЦІНЮВАННЯ

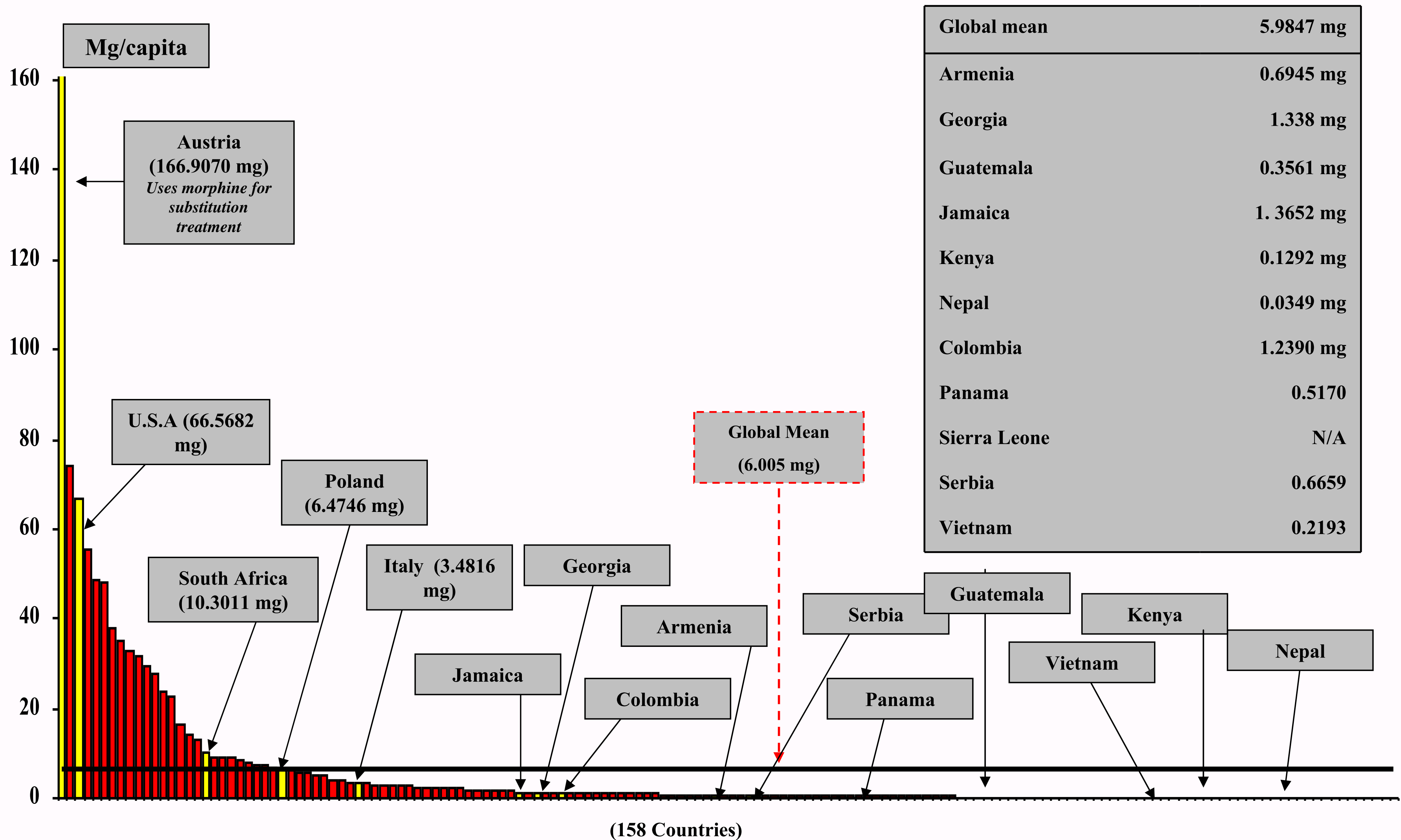
WORLD HEALTH ORGANIZATION
ВСЕСВІТНЯ ОРГАНІЗАЦІЯ ОХОРОНИ ЗДОРОВ'Я

Polish
Portuguese
Romanian
Russian
Serbian
Spanish
Swahili
Tagalog
Turkish
Ukrainian
Vietnamese

WHO Public Health Model



Global Consumption of Morphine, 2008



The means are calculated by adding the individual mg/capita statistics for all countries and then dividing by the number of countries; data does not Include information for countries from which the INCB did not receive a report

Source: International Narcotics Control Board; United Nations population data
By: Pain & Policy Studies Group, University of Wisconsin/WHO Collaborating Center, 2010

Log

Morphine (mg/capita)

100
10
1
0

10,000 20,000 30,000 40,000 50,000 60,000 70,000 80,000 90,000 100,000 110,000

GDP

Lin

1964

Color

Geographic Region

- AFRO
- AMRO
- EMRO
- EURO
- SEARO
- WPRO

Size

Population

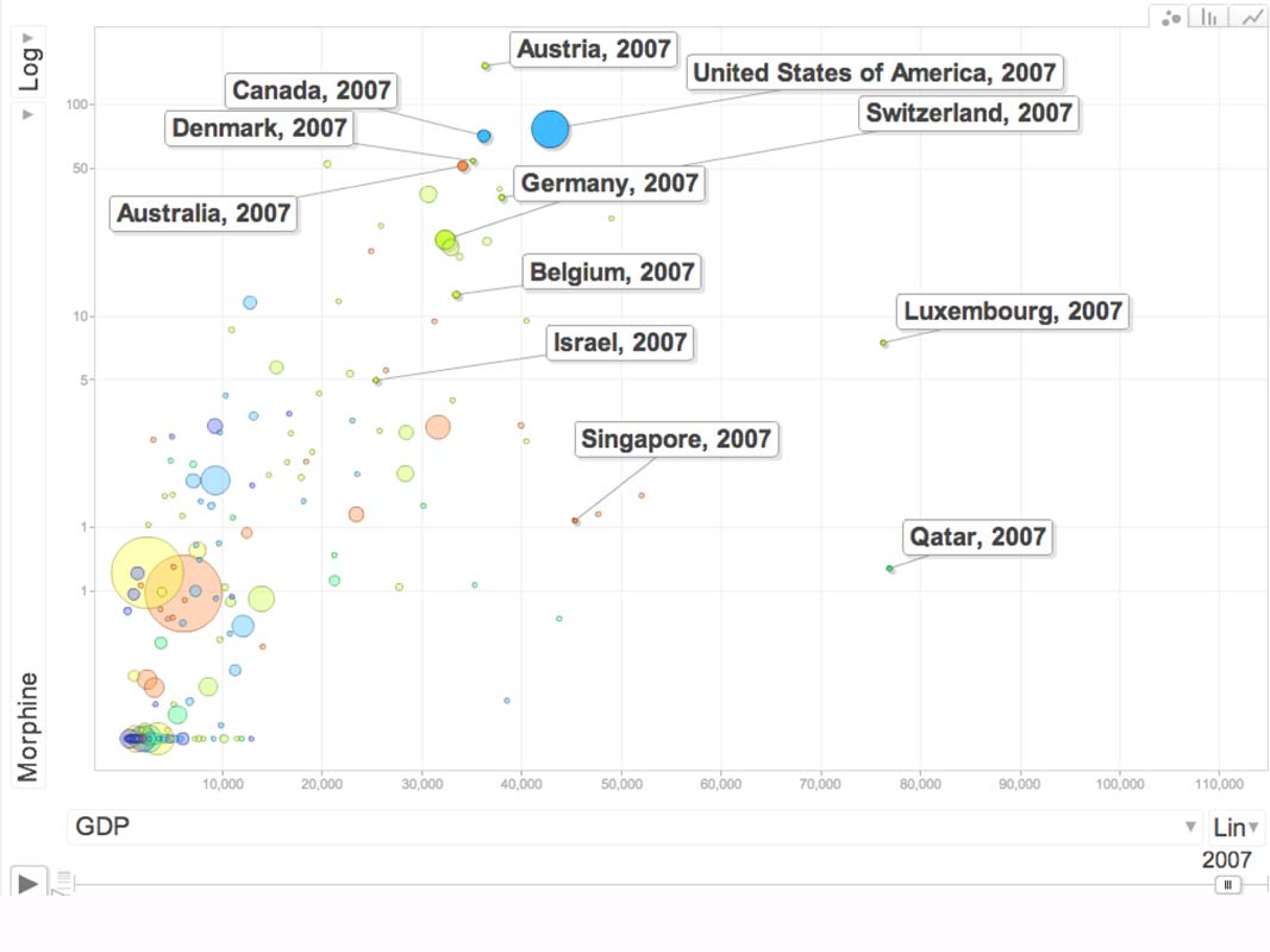
1400000000

Select

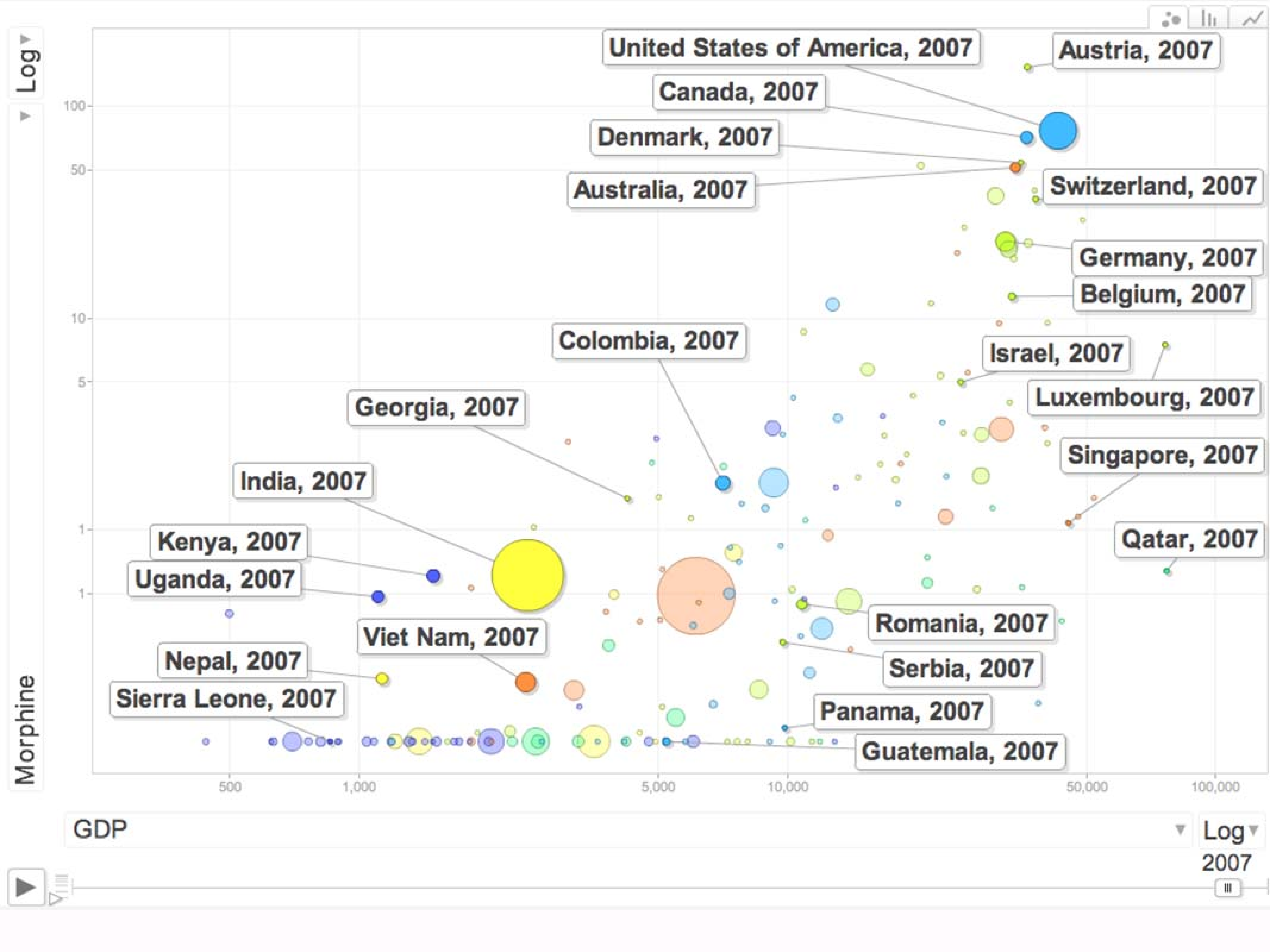
- Afghanistan
- Albania
- Algeria
- Andorra
- Angola
- Anguilla
- Antigua and Barbuda
- Argentina
- Armenia
- Aruba
- Ascension Island
- Australia
- Austria

Trails

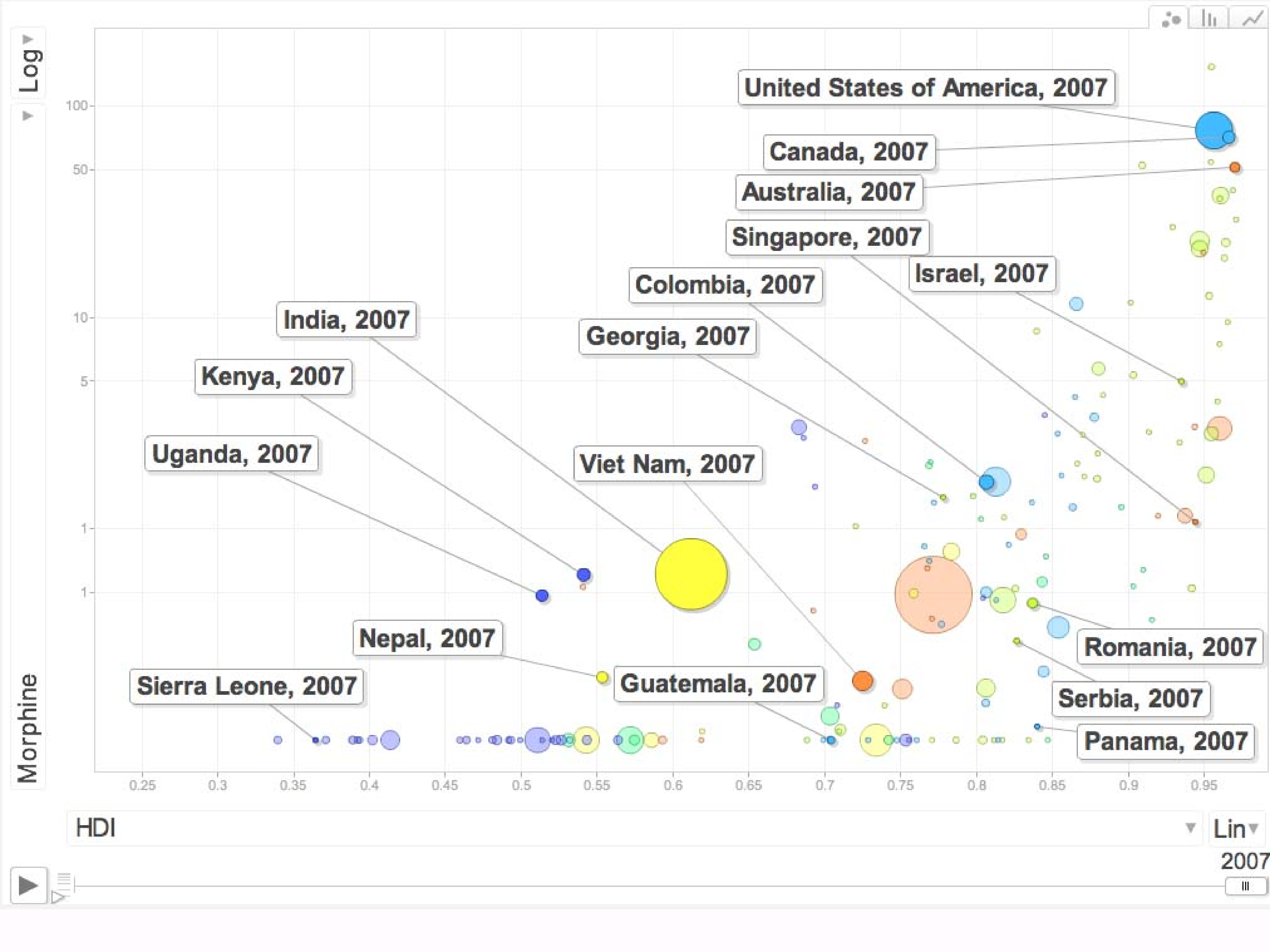
Screencast-O-Matic.com



Log
Morphine
Austria, 2007
United States of America, 2007
Canada, 2007
Switzerland, 2007
Denmark, 2007
Germany, 2007
Australia, 2007
Belgium, 2007
Luxembourg, 2007
Israel, 2007
Singapore, 2007
Qatar, 2007
100
50
10
5
1
1
10,000
20,000
30,000
40,000
50,000
60,000
70,000
80,000
90,000
100,000
110,000
GDP
Lin
2007



United States of America, 2007
Austria, 2007
Canada, 2007
Denmark, 2007
Australia, 2007
Switzerland, 2007
Germany, 2007
Belgium, 2007
Colombia, 2007
Israel, 2007
Luxembourg, 2007
Georgia, 2007
Singapore, 2007
India, 2007
Qatar, 2007
Kenya, 2007
Uganda, 2007
Romania, 2007
Viet Nam, 2007
Serbia, 2007
Nepal, 2007
Sierra Leone, 2007
Panama, 2007
Guatemala, 2007
Log
Morphine
100
50
10
5
1
1
500
1,000
5,000
10,000
50,000
100,000
GDP
Log
2007



Log
Morphine
United States of America, 2007
Canada, 2007
Australia, 2007
Singapore, 2007
Israel, 2007
Colombia, 2007
India, 2007
Georgia, 2007
Kenya, 2007
Uganda, 2007
Viet Nam, 2007
Nepal, 2007
Guatemala, 2007
Sierra Leone, 2007
Romania, 2007
Serbia, 2007
Panama, 2007
100
50
10
5
1
1
0.25
0.3
0.35
0.4
0.45
0.5
0.55
0.6
0.65
0.7
0.75
0.8
0.85
0.9
0.95
HDI
Lin
2007

Essential Medicines

16th edition (updated)

2010 WHO Model List

2. ANALGESICS, ANTIPYRETICS, NON-STEROIDAL ANTI-INFLAMMATORY MEDICINES (NSAIMs), MEDICINES USED TO TREAT GOUT AND DISEASE MODIFYING AGENTS IN RHEUMATOID DISORDERS (DMARDs)

2.1 Non-opioids and non-steroidal anti-inflammatory medicines (NSAIMs)

acetylsalicylic acid **Suppository: 50 mg to 150 mg. Tablet: 100 mg to 500 mg.**

Ibuprofen **Tablet: 200 mg; 400 mg.** >3 months.

paracetamol* **Oral liquid: 125 mg/5 ml. Suppository: 100 mg. Tablet: 100 mg to 500 mg.**
*** Not recommended for anti inflammatory use due to lack of proven benefit to that effect.**

2.2 Opioid analgesics

Codeine **Tablet: 15 mg (phosphate); 30 mg (phosphate).**

Morphine **Injection: 10 mg (morphine hydrochloride or morphine sulfate) in 1 ml ampoule.**
Oral liquid: 10 mg (morphine hydrochloride or morphine sulfate)/5 ml.
Tablet: 10 mg (morphine sulfate).
Tablet (prolonged release): 10 mg; 30 mg; 60 mg (morphine sulfate)

International Association for Hospice & Palliative Care

Promoting Hospice & Palliative Care Worldwide

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Home >> Who We Are >>> What We Do >>>> What You Can Do

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Our Mission is to collaborate and work to improve the quality of life of patients with advanced life-threatening conditions and their families, by advancing hospice and palliative care programs, education, research, and favorable policies around the world.

Our Vision is to help to increase and optimize the availability of and access to hospice and palliative care for patients and their families throughout the world.

We achieve this by:

- facilitating and providing palliative care education and training opportunities for care providers
- acting as an information resource for professionals, health care providers and policy makers
- developing collaborative strategies for hospice and palliative care providers, organizations, institutions and individuals

Learn More about what we do here

What is Hospice & Palliative Care? Click here

See the list and bios of the IAHPC Board of Directors and Staff Members here

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Need more information? Please contact us

IAHPC LIST OF ESSENTIAL MEDICINES FOR PALLIATIVE CARE ©			
Medication	**Formulation**	**IAHPC Indication for PC**	**WHO Essential Medicines Model List Section, subsection and Indication**
*Amitriptyline**	50-150 mg tablets	Depression Neuropathic pain	24.2.1 - Depressive disorders
Bisacodyl	10 mg tablets 10 mg rectal suppositories	Constipation	Not included
Carbamazepine**	100- 200 mg tablet	Neuropathic pain	5 - Anticonvulsants/antiepileptics 24.2.2 - Bipolar disorders
Citalopram *(or any other equivalent generic SSRI except paroxetine and fluvoxamine)*	20 mg tablets 10 mg/5ml oral solution 20-40 mg injectable	Depression	Not included
Codeine	30 mg tablets	Diarrhea Pain - mild to moderate	2.2 - Opioid analgesics 17.5.3 - Antidiarrheal
Dexamethasone	0.5-4 mg tablets 4 mg/ml injectable	Anorexia Nausea Neuropathic pain Vomiting	3 - Antiallergics and anaphylaxis 8.3 - Hormones and antihormones
Diazepam	2.5 -10 mg tablets 5 mg/ml injectable 10 mg rectal suppository	Anxiety	1.3 - Preoperative sedation short term procedures 5 - Anticonvulsants/antiepileptics 24.3 - Generalized anxiety, sleep disorders
Diclofenac	25-50 mg tablets 50 and 75 mg/3ml injectable	Pain - mild to moderate	Not included
Diphenhydramine	25 mg tablets 50 mg/ml injectable	Nausea Vomiting	Not included
Fentanyl (transdermal patch)	25 micrograms/hr 50 micrograms/hr	Pain - moderate to severe	Not included
Gabapentin	tablets 300 mg or 400 mg	Neuropathic pain	Not included
Haloperidol	0.5 - 5 mg tablets 0.5 - 5 mg drops 0.5 - 5 mg/ml injectable	Delirium Nausea Vomiting Terminal restlessness	24.1- Psychotic disorders
Hyoscine butylbromide	20 mg/1ml oral solution 10 mg tablets 10 mg/ml injectable	Nausea Terminal respiratory congestion Visceral pain Vomiting	Not included
Ibuprofen	200 mg tablets 400 mg tablets	Pain - mild to moderate	2.1 - Non opioids and NSAIMs
Levomepromazine	5 - 50 mg tablets 25 mg/ml injectable	Delirium Terminal restlessness	Not included
Loperamide	2 mg tablets	Diarrhea	Not included
Lorazepam***	0.5-2 mg tablets 2 mg/ml liquid/drops 2-4mg/ml injectable	Anxiety Insomnia	Not included
Megestrol Acetate	160 mg tablets 40 mg/ml solution	Anorexia	Not included
Methadone (immediate release)	5mg tablets 1 mg/ml oral solution	Pain - moderate to severe	24.5 - Substance dependence

Metoclopramide	10 mg tablets 5 mg/ml injectable	Nausea Vomiting	17.2 - Antiemetics
Midazolam	1-5 mg/ml injectable	Anxiety Terminal restlessness	Not included
Mineral oil enema			Not included
Mirtazapine *(or any other generic dual action NassA or SNRI)*	15-30 mg tablets 7.5-15 mg injectable	Depression	Not included
Morphine	Immediate release: 10-60 mg tablets Immediate release: 10mg/5ml oral solution Immediate release: 10 mg/ml injectable Sustained release: 10 mg tablets Sustained release: 30 mg tablets	Dyspnea Pain - moderate to severe	2.2 - Opioid analgesics
Octreotide	100 mcg/ml injectable	Diarrhea Vomiting	Not included
Oral rehydration salts		Diarrhea	17.5.1 - Oral rehydration
Oxycodone	5 mg tablet	Pain - moderate to severe	Not included
Paracetamol (Acetaminophen)	100-500 mg tablets 500 mg rectal suppositories	Pain - mild to moderate	2.1 - Non opioids and NSAIMs
Prednisolone *(as an alt to Dexamethasone)*	5 mg tablet	Anorexia	3 - Antiallergics and anaphylaxis 8.3 - Hormones and antihormones 21.2 - Anti inflamatory agents
Senna	8.6 mg tablets	Constipation	17.4 - Laxatives
Tramadol	50 mg immediate release tablets/capsules 100mg/1ml oral solution 50mg/ml injectable	Pain - mild to moderate	Not included
Trazodone	25-75 mg tablets 50 mg injectable	Insomnia	Not included
Zolpidem (still patented)	5-10 mg tablets	Insomnia	Not included

International Association of Hospice and Palliative Care

List of Essential Medicines for Palliative Care

(http://www.hospicecare.com/resources/pdf-docs/iahpc-list-em.pdf)

- ✓ Codeine,
- ✓ Fentanyl,
- ✓ Methadone,
- ✓ Morphine (immediate and sustained release),
- ✓ Oxycodone,
- ✓ Tramadol

NOTE: NO GOVERNMENT SHOULD APPROVE MODIFIED RELEASE MORPHINE, FENTANYL OR OXYCODONE WITHOUT ALSO GUARANTEEING WIDELY AVAILABLE NORMAL RELEASE ORAL MORPHINE.

original article

Annals of Oncology
doi:10.1093/annonc/mdp581

Formulary availability and regulatory barriers to accessibility of opioids for cancer pain in Europe: a report from the ESMO/EAPC Opioid Policy Initiative

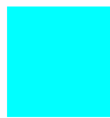
N. I. Cherny[1,2,3]*, J. Baselga[4,5], F. de Conno[6] & L. Radrbruch[6,7]

[1]Cancer Pain and Palliative Medicine Unit, Department of Oncology, Shaare Zedek Medical Center, Jerusalem, Israel; [2]European Society for Medical Oncology; [3]Palliative Care Working Group; [4]Medical Oncology Service, Vall d'Hebron University Hospital, Barcelona, Spain; [5]European Society for Medical Oncology; [6]European Association for Palliative Care and [7]Palliative Medicine, Aachen University, Aachen, Germany

Received 3 October 2009; revised 25 November 2009; accepted 25 November 2009

Opioid availability and cost: West Europe

	Codeine	Propox	HC/DHC	BuprPO	BuprTD	MoIR	MoCR	MoInj	OcIR	OcCR	Methad.	FentTD	FentTM	HmIR	HmCR	PethInj
Finland																
France																
Norway																
Austria																
Portugal																
Italy																
Denmark																
Israel																
Netherlands																
Cyprus																
Greece																
Germany																
Luxemburg																
Spain																
Switzerland																
UK																
Belgium																
Iceland																
Turkey																


Free

<25%
Cost

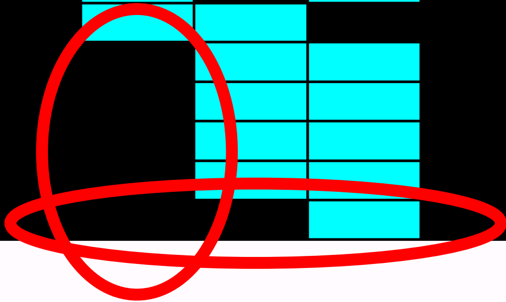
25-50%
Cost

50-75%
Cost

100%
cost

Opioid availability and cost: Eastern Europe

	Codeine	Propox	HC/DHC	BuprPO	BuprTD	MoIR	MoCR	MoInj	OcIR	OcCR	Methad.	FentTD	FentTM	HmIR	HmCR	PethInj
Czech R.																
Croatia																
Latvia																
Rumania																
Slovak R.																
Hungary																
Estonia																
Serbia																
Bulgaria																
Moldova																
Poland																
Russia																
Monten.																
Maced.																
Bosnia-H																
Lithuania																
Belarus																
Albania																
Georgia																
Ukraine																

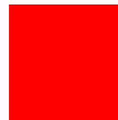


Free

<25%
Cost

25-50%
Cost

50-75%
cost



100%
cost

United States of America, 2006

Poland, 2006

Ukraine, 2000

Kyrgyzstan, 2006

Turkey, 2006

Republic of Moldova, 2006

Russian Federation, 2006

Armenia, 2006

0.3 0.4 0.5 0.6 0.7 0.8 0.9

Color

Geographic

AFRO
AMRO
EMRO
EURO
SEARO
WPRO

Size

Population

140000000

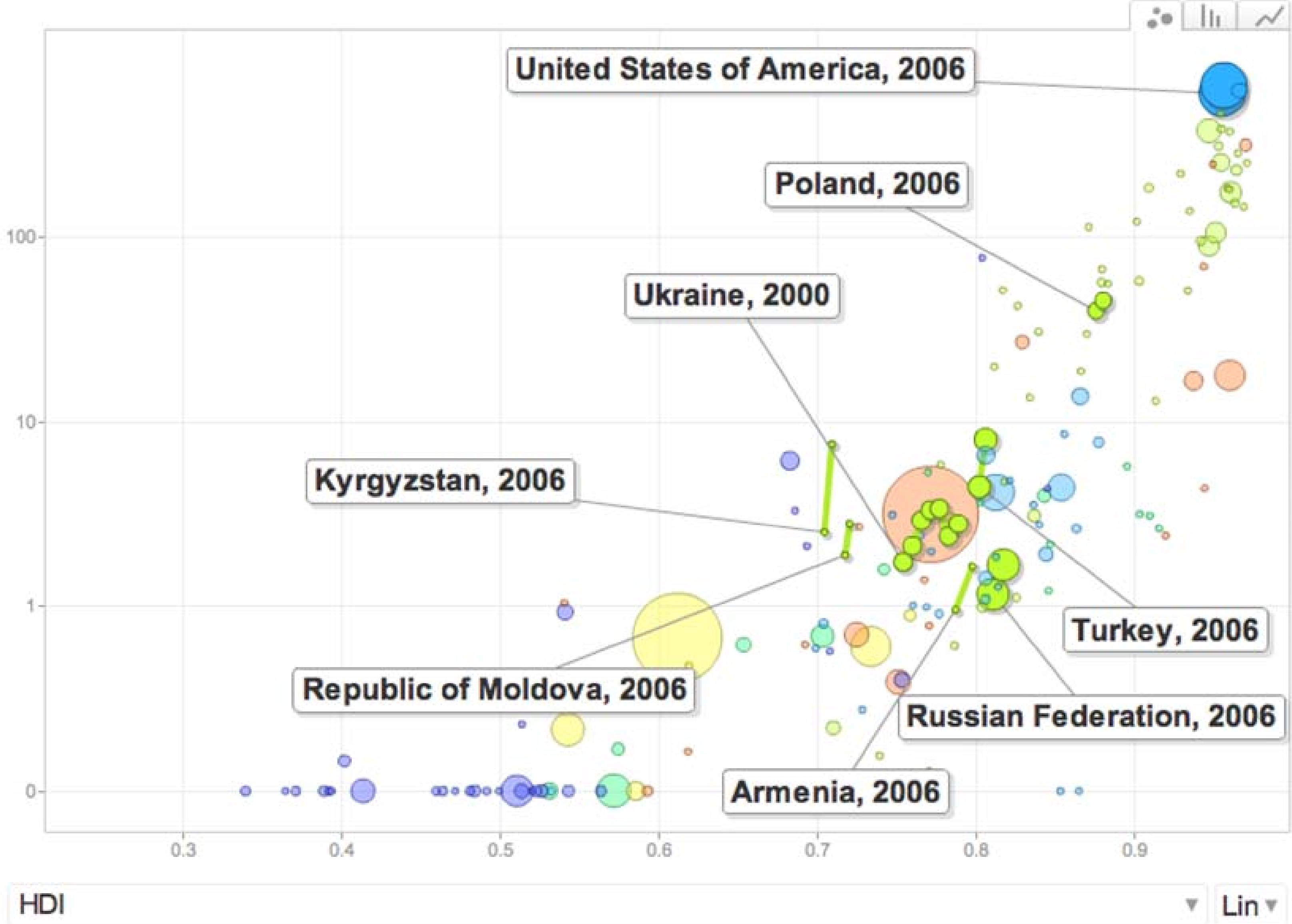
Select

Turkey
Turkmenistan
Turks and Cai
Tuvalu
USSR (historic
Uganda
Ukraine
United Arab E
United Kingdo
United Republ
United States
Uruguay
Uzbekistan

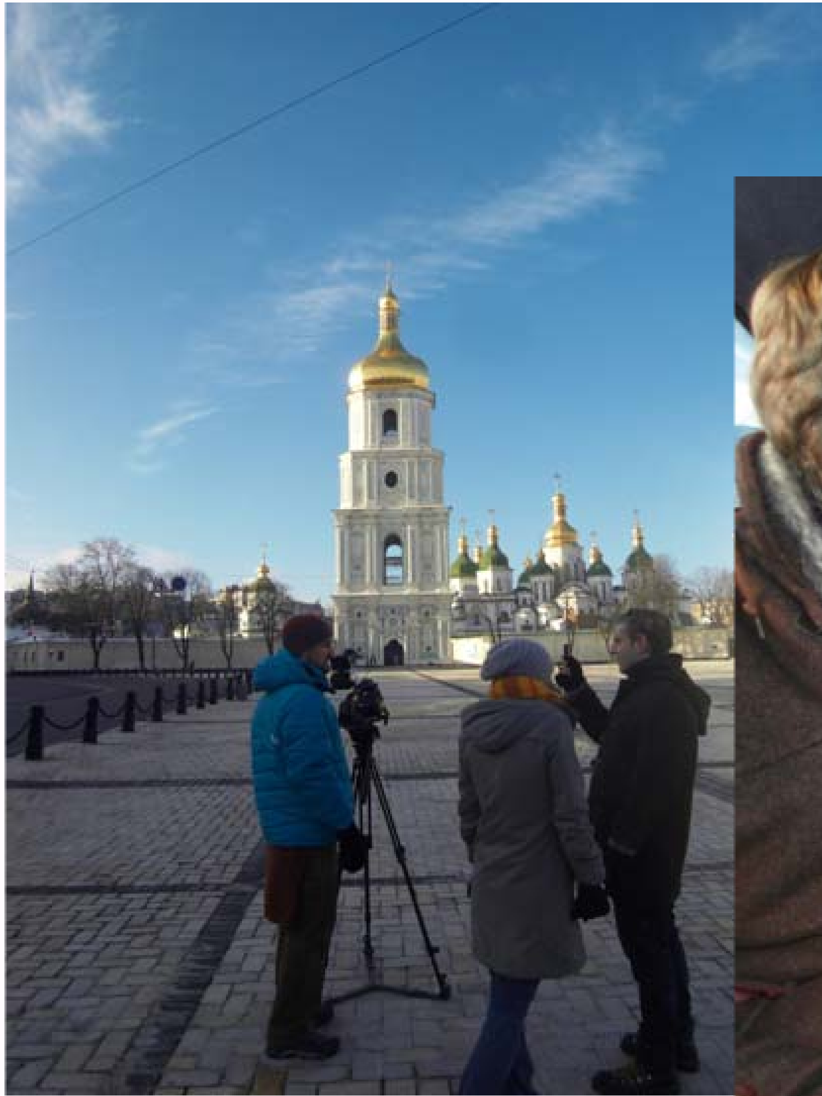
Trails

Lin

2006



United States of America, 2006
Poland, 2006
Ukraine, 2000
Kyrgyzstan, 2006
Republic of Moldova, 2006
Turkey, 2006
Russian Federation, 2006
Armenia, 2006
Log
Morphine Equivalence (mg/capita)
100
10
1
0
0.3
0.4
0.5
0.6
0.7
0.8
0.9
HDI
Lin
2007
Color
Geographic Region
AFRO
AMRO
EMRO
EURO
SEARO
WPRO
Size
Population
1400000000
Select
Deselect all
Turkey
Turkmenistan
Turks and Caicos Islands
Tuvalu
USSR (historical)
Uganda
Ukraine
United Arab Emirates
United Kingdom
United Republic of Tanzania
United States of America
Uruguay
Uzbekistan
Trails

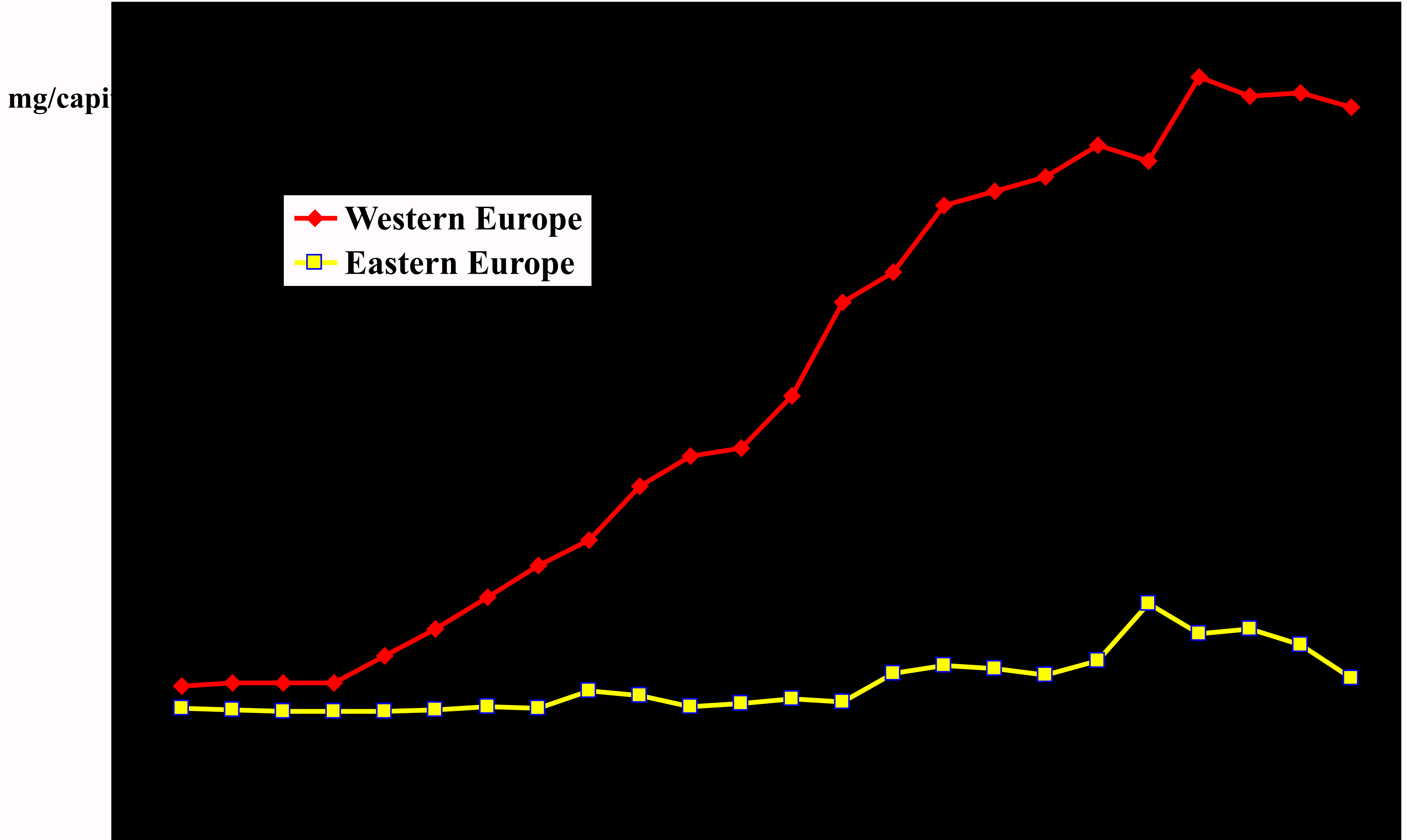


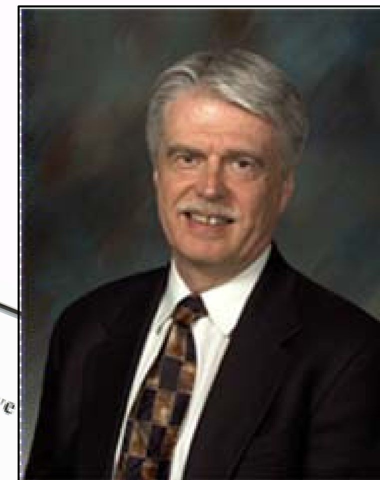
ЛОМОВА
ТАИСИЯ
АФАНАСЬЕВН
19.V.1938.

LOWER

FLOWER

Consumption of Morphine 1980 - 2003 East vs. West Europe (mg/capita/yr)





Joranson,

Lancet 2006

Colectivul de Specialisti in Terapia Durerii si Ingrijiri Paliative

Pain & Policy Studies Group,
Centrul OMS, Universitatea Wisconsin

Recomandari catre Ministerul Sanatatii

16 iulie 2003

Commission of Specialists in Pain Therapy and Palliative Care

Pain & Policy Studies Group,
WHO Centre, Wisconsin University

Recommendations to the Ministry of Health

16 July 2003

World Health Organization Collaborating Center for Pain Policy and Palliative Care

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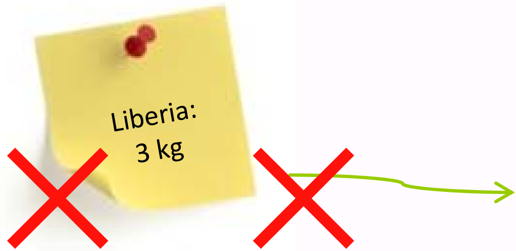
What does it take to get access to pain relief?



Competent authority submits annual national morphine estimate

INCB confirms morphine quantity

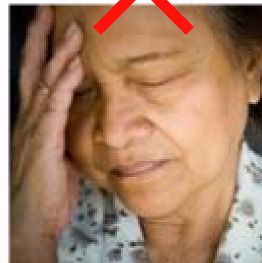
Government or wholesaler places order with registered supplier

Product delivered to central medical stores

Distributed to district medical stores

Distributed to facility

Clinician asks about pain



Patient reports pain

Clinician writes prescription

Patient fills prescription

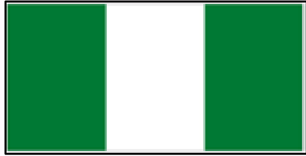
Patient receives monitoring and follow-up

PPSG International
Pain Policy Fellowship (IPPF)

- Competitive process
- Self-Identified champions.

- Supported by
  - Open Society Institute IPPI: 2006-
  - US Cancer Pain Relief Committee: 2006-
  - Livestrong: 2010-

2006 International Pain Policy Fellowship



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Serbia

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Argentina

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October 2006 Madison, Wisconsin

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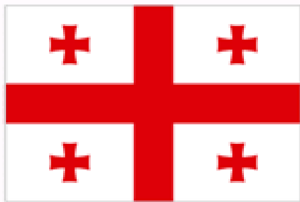

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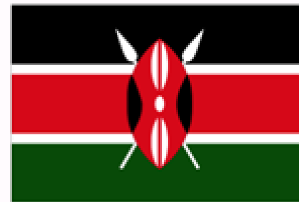

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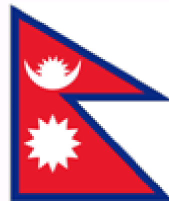
Republic of Moldova



Dr. Bishnu Dutta Paudel
Mr. Radha Raman Prasad Teli
Nepal

Pain & Policy Studies Group
University of Wisconsin
June 2008, Madison, Wisconsin

Supported by the
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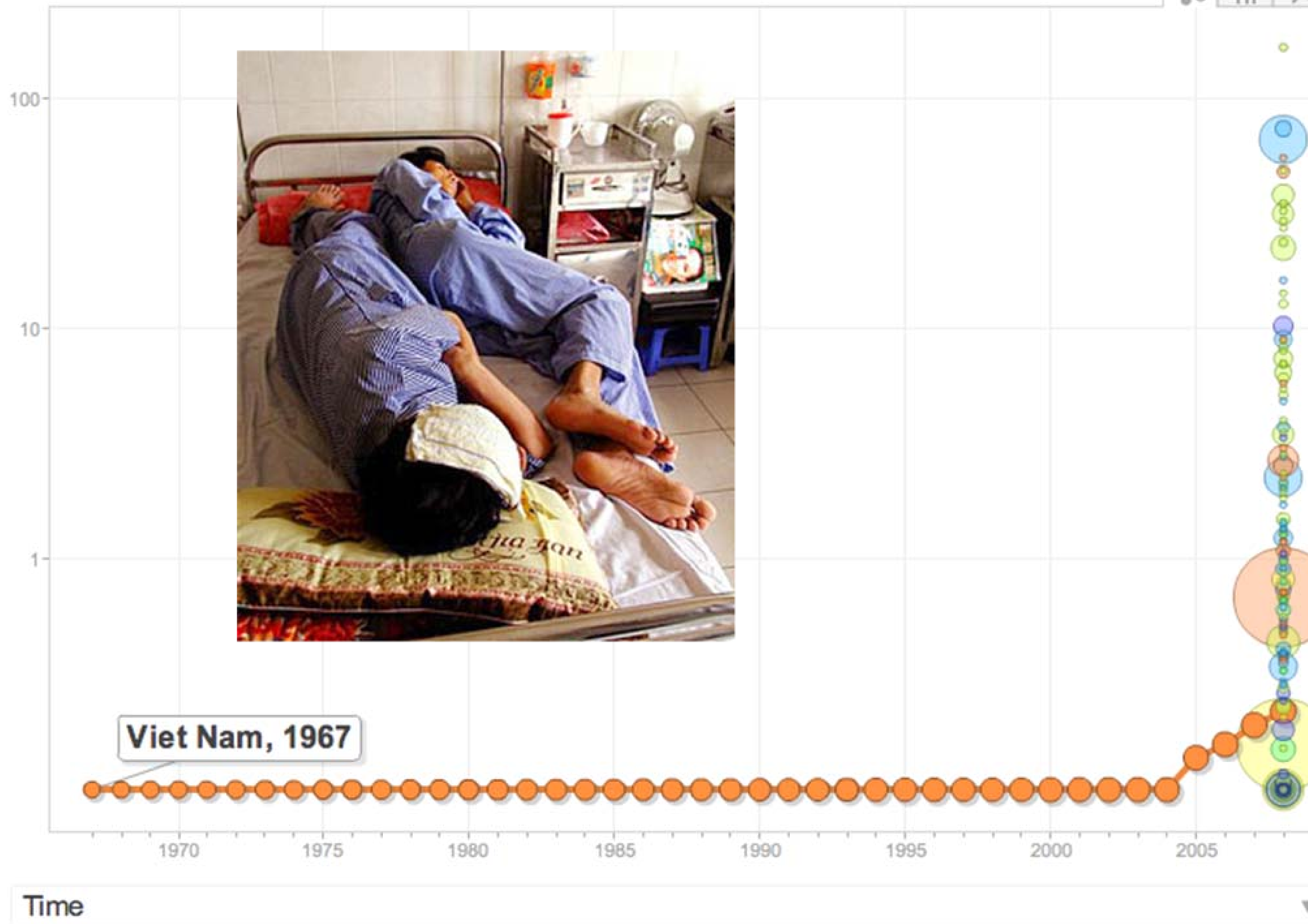

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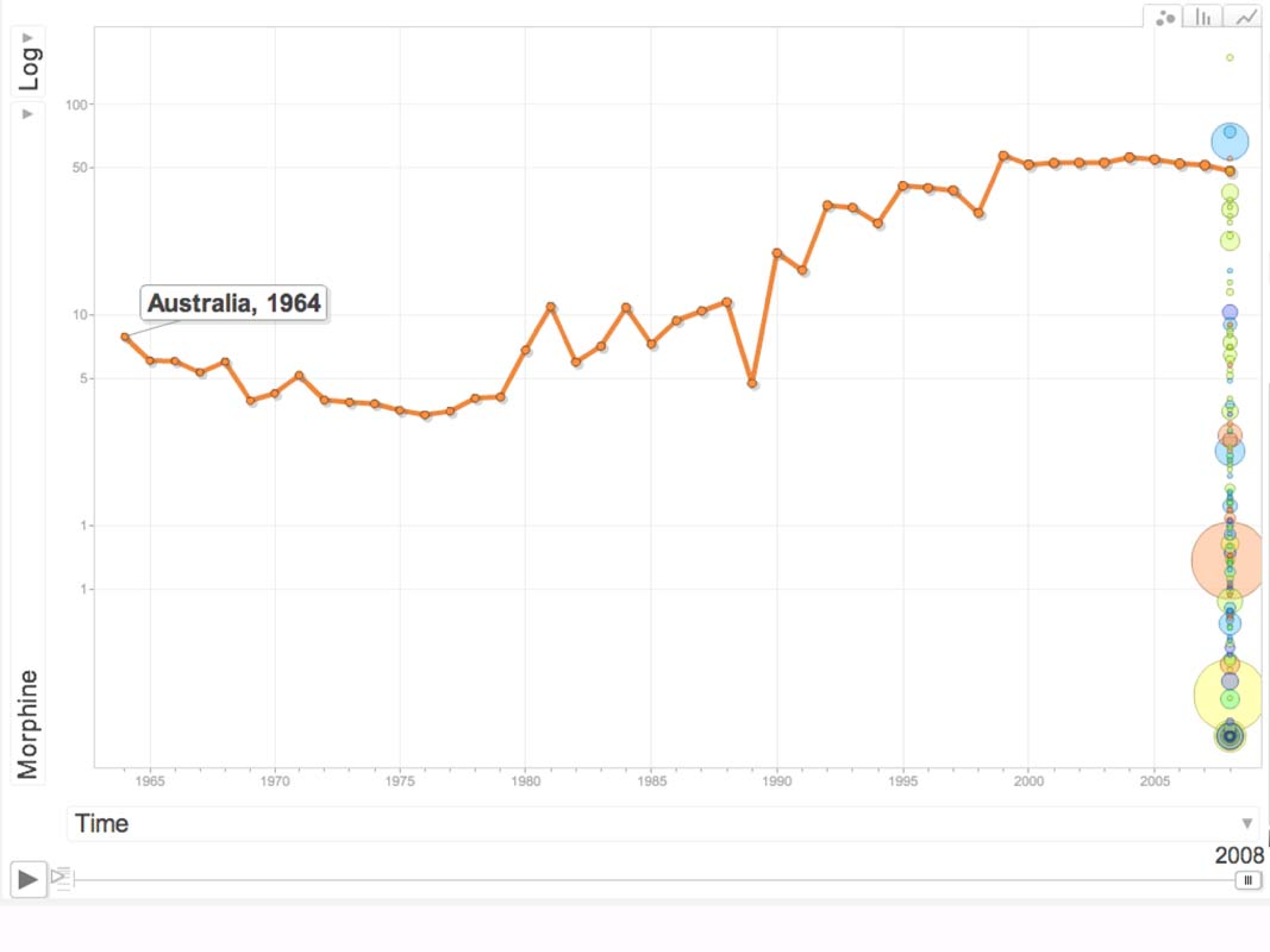

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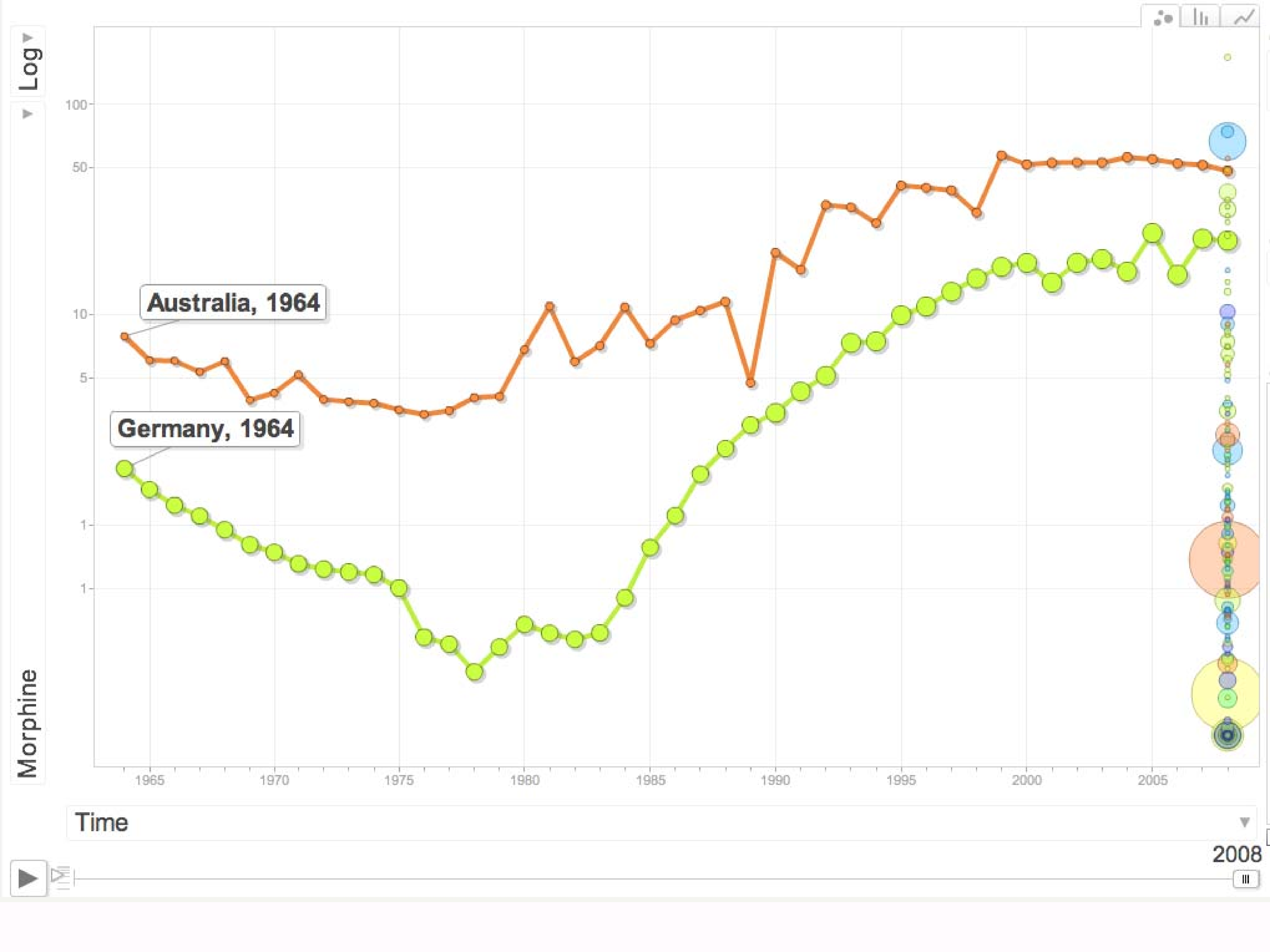

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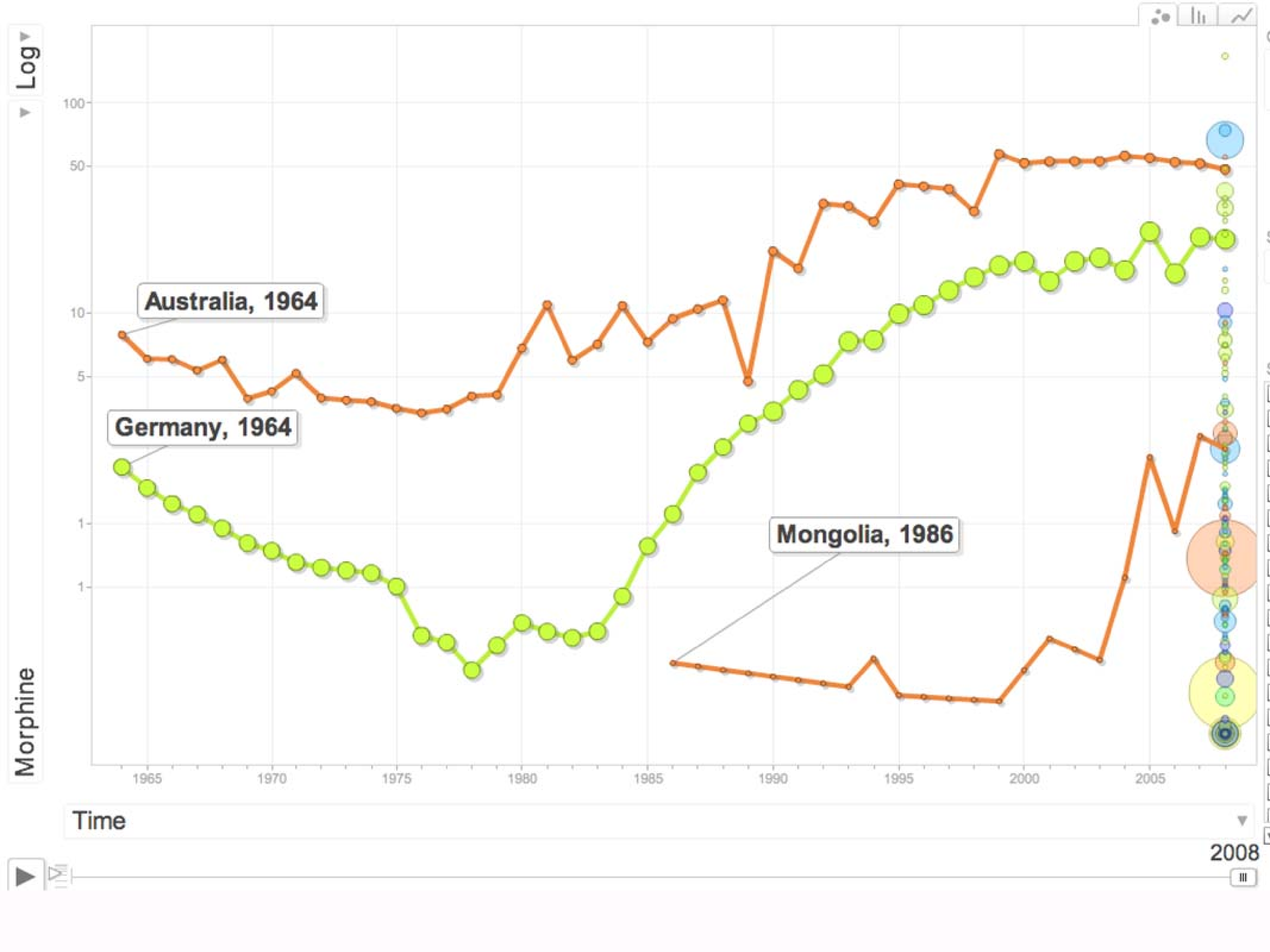

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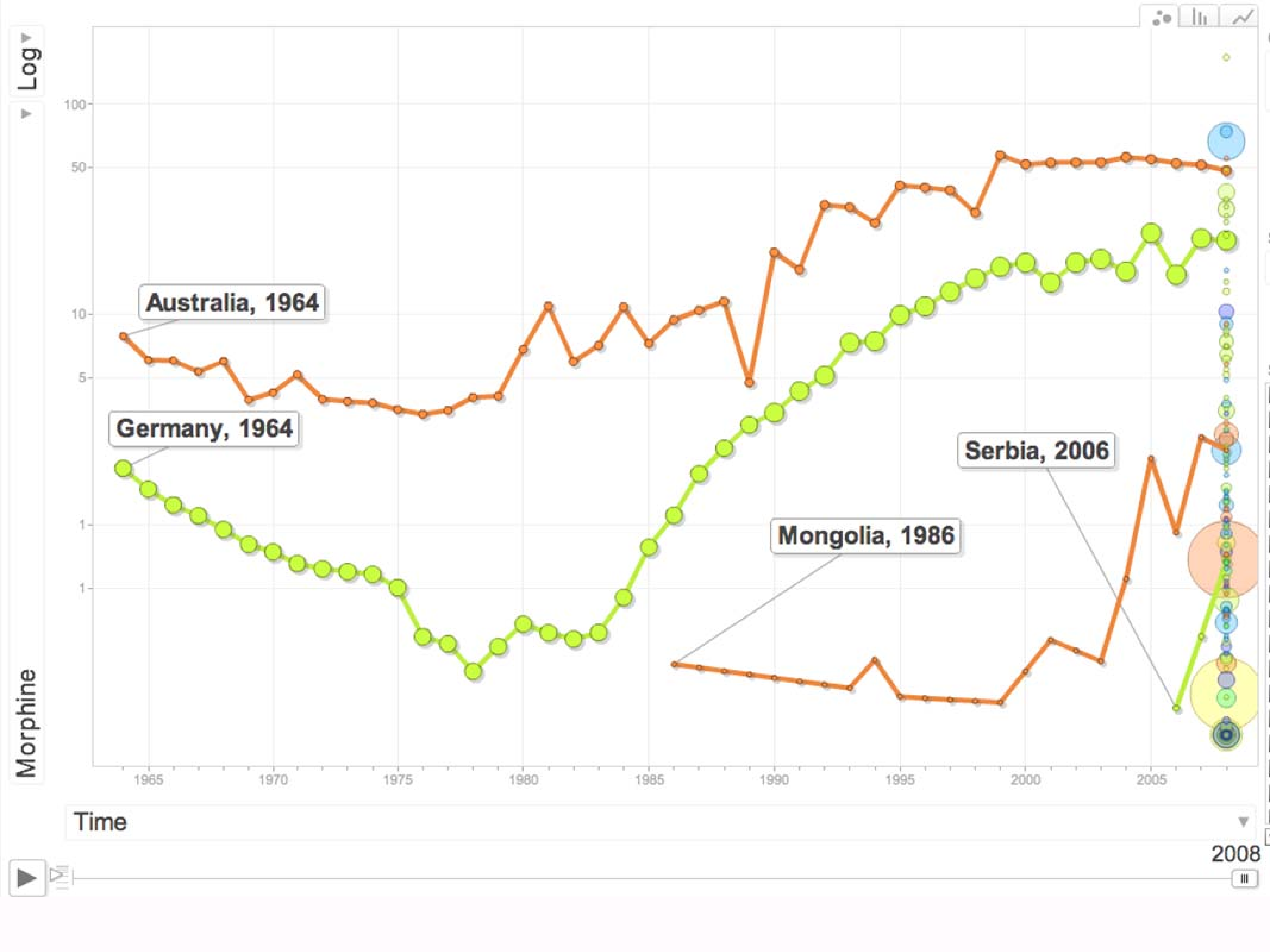

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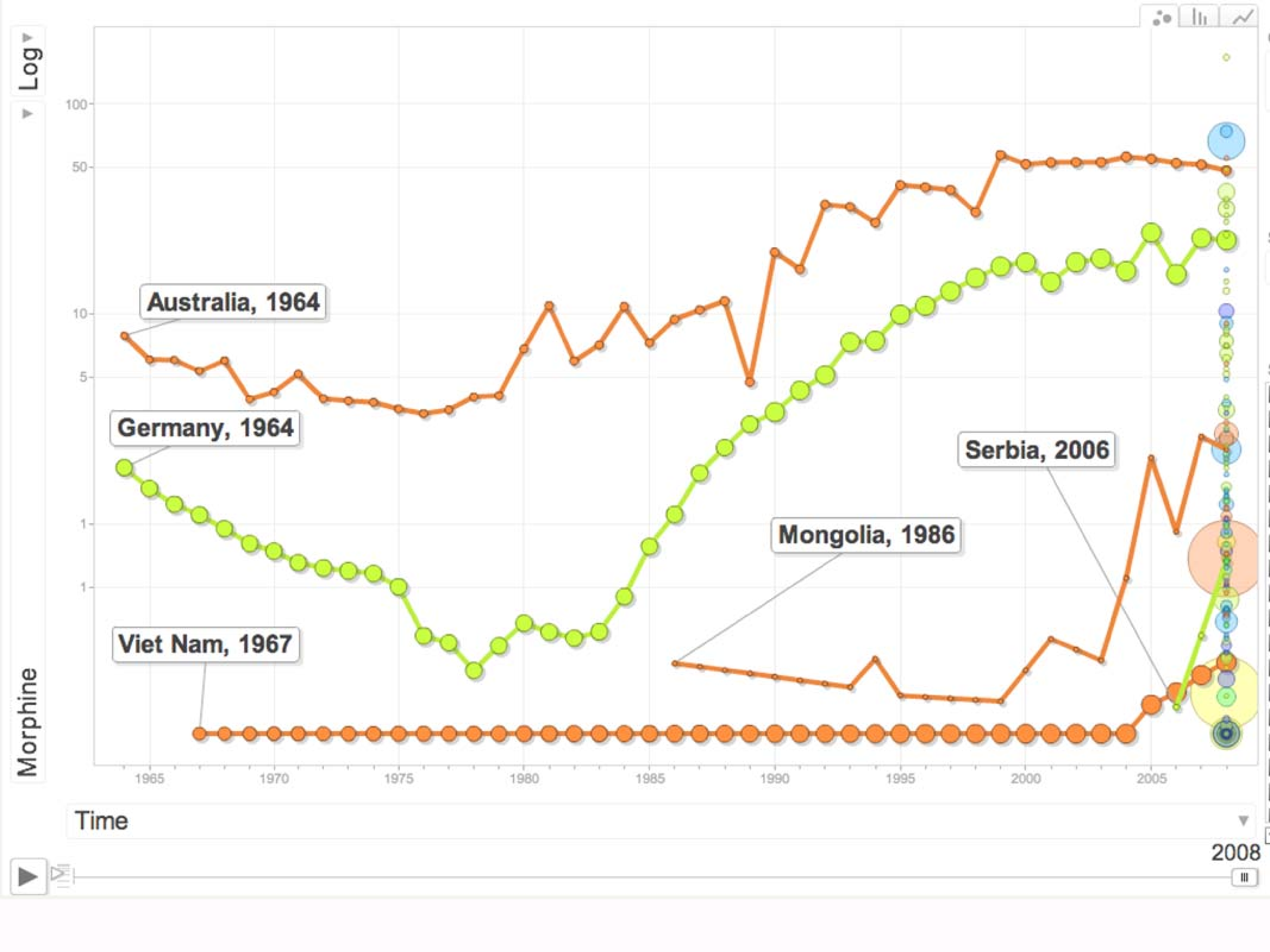

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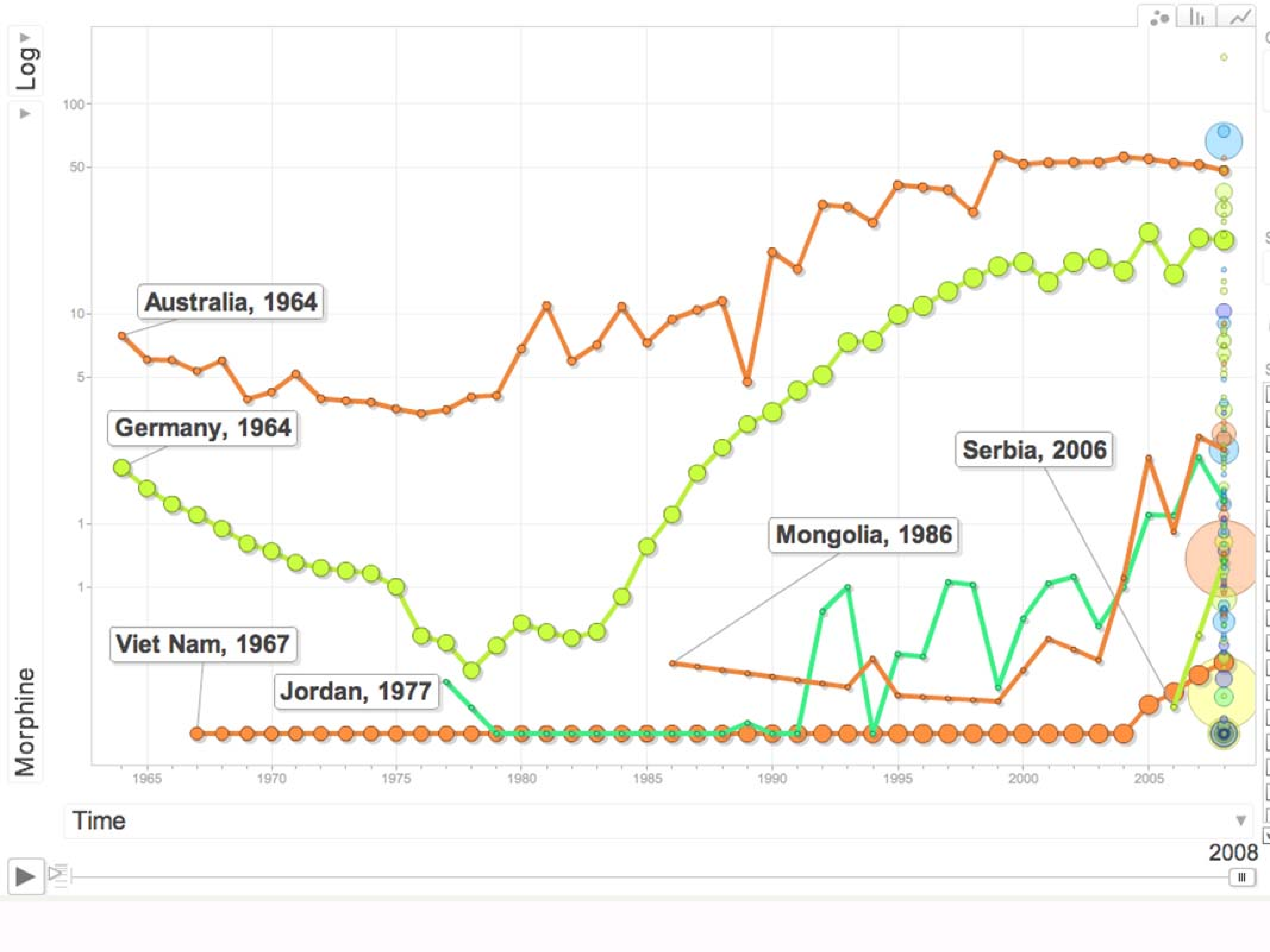

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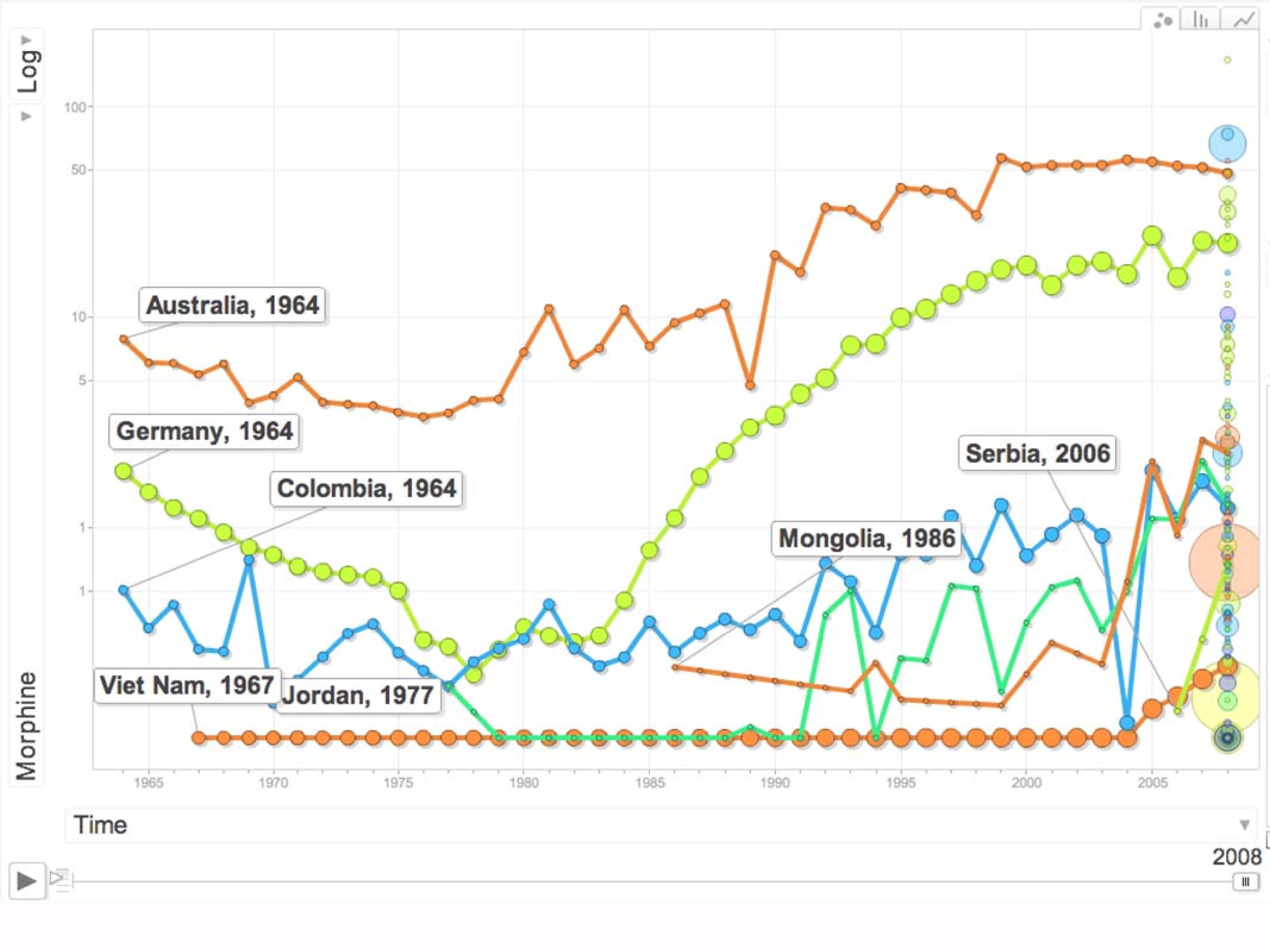

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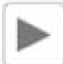

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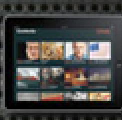
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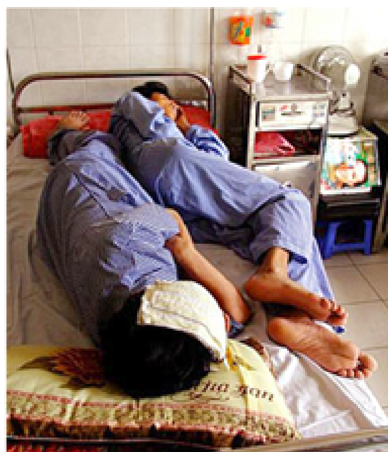
Morphine Remains Scarce for Pain Sufferers Worldwide

By MARTHA ANN OVERLAND / HANOI Monday, Jun. 07, 2010



HIV/AIDS patients lie on a bed at the National Institute of Tropical Medicines in Hanoi on May 6, 2005
Reuters

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After the hospital sent Nguyen Van Dung home to die, his family watched helplessly as he wasted away from complications due to AIDS. And he did not go gently. "He was in such pain," says Dung's 73-year-old mother. "It was like seeing him on fire."

THE POLITICS OF PAIN

Pain relief is often taken for granted in the Western world, but in about 150 countries the use of morphine is severely restricted. **Tatum Anderson** investigates how this has come about, and what steps are being taken to stop patients living and dying in extreme pain

Dozens of recycled plastic mineral water bottles are filled with brightly coloured solutions. The bottles are full of oral morphine, colour coded for different strengths—green for the weakest, then pink, and blue for the strongest. Every day, teams of nurses take them to paediatric and cancer wards and patients living at home near Kampala, Uganda.

In a country where fewer than 5% of cancer patients ever receive radiotherapy or chemotherapy, and with a high HIV/AIDS prevalence, the need for pain relief is crucial, says Anne Merriman, an Irish palliative care specialist who set up Hospice Africa there in 1993.

She agreed to establish the service on condition the government changed its rules on morphine provision. Previously only doctors, dentists, and vets were allowed to prescribe opioids—although midwives could prescribe pethidine. In the early 1990s oral morphine was used only rarely, and with a shortage of doctors, few patients ever met a health worker allowed to prescribe it. In 1992 the government agreed to allow nurses and clinical officers trained in palliative care at Hospice Uganda to prescribe oral morphine. "The government had seen so much suffering with the AIDS epidemic. Everyone had a family member who had died in agony," says Dr Merriman.

Lack of oral morphine

Today, despite Hospice Africa's attempts to export the model, widely available oral morphine remains an exception rather than the rule. In about 150 countries,[1] including Indonesia and India, severe restrictions on the use of morphine for pain relief means patients are still living and dying in severe pain.

Although WHO guidelines for the treatment of moderate to severe pain in cancer state there can be no substitute for [strong] opioid analgesics such as morphine, "weaker drugs are often used to treat pain in people with terminal cancer and HIV/AIDs patients. Gabriel Madiye, executive director of the Shepherd's Hospice in Sierra Leone says: "We have tried codeine [a weak opioid], diclofenac, and paracetamol. They are not enough."

Recently WHO estimated that 5.5 million people with terminal cancer, a million late stage HIV/AIDS patients, and 800 000 patients with unintentional injuries or injuries caused by violence are not receiving the pain relief they need. Also, many patients with conditions, such as sickle cell anaemia, those recovering from surgery, and HIV/AIDs patients on antiretrovirals, require relief but do not get it. Controlled drugs that are used to treat drug addiction or obstetric complications, such as ergometrine, are severely restricted too.[1]

Most countries do not have bans on opioids for medical use, but their policies and rules are so onerous the result is lack of access for patients. In some countries only oncologists and palliative care specialists are allowed to prescribe opioids, or they can only prescribe extremely limited amounts. Some formulations, such as oral morphine, are not allowed (see box 1). Indian pharmacies require so many licences to stock controlled drugs that many do not bother (see

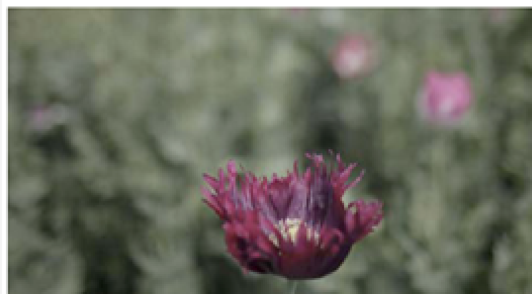
Box 1 | Armenia

Hrant Karapetyan and colleagues have set up Armenia's first dedicated pain control and palliative care centre, but face many restrictions.

Most physicians cannot prescribe opioids, for example. "It's a crazy situation," says Dr Karapetyan. "I give lectures for oncologists in pain management. My student oncologists have permission to prescribe morphine, I have not."

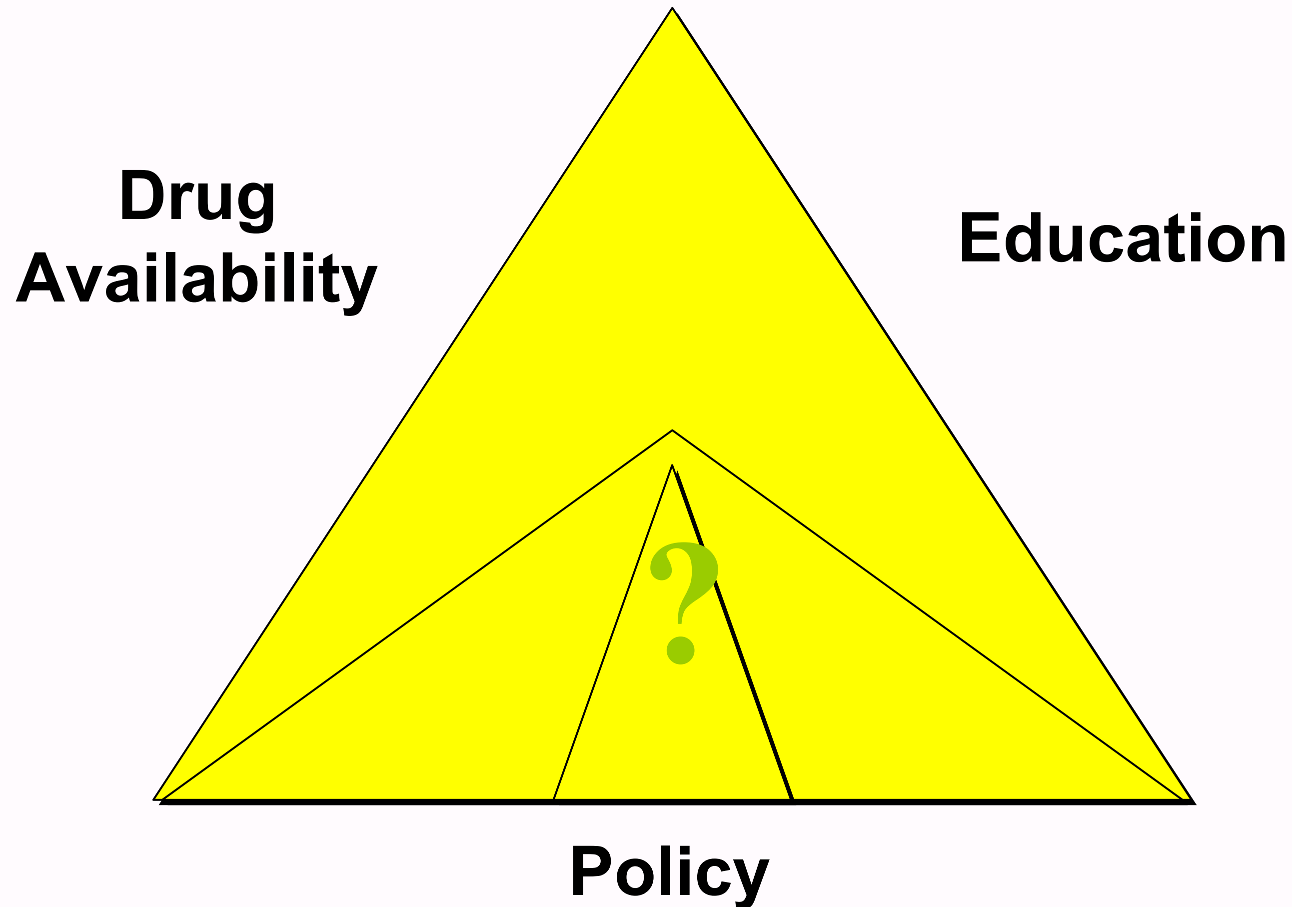
The only morphine available is an injectable form that can be prescribed for 10 days—although outpatient prescriptions are often limited to three days at a time. Very ill patients living in rural areas are forced to travel to municipalities each time they want another supply, says the Open Society Institute, which has studied Armenia palliative care. More worryingly, oncologists rarely prescribe more than 10 mg per day. "It is a very low dose and does not give adequate analgesia," Dr Karapetyan says.

Things are improving gradually. Oral morphine may reach Armenia later this year, and palliative care training courses are planned. Finances remain a problem, however. Dr Karapetyan has been paying for the centre from his own pocket and staff work without pay. "The situation is very bad," he says.



A poppy flower in a field in a Taliban controlled area of Helmand province, Afghanistan

WHO Public Health Model



"We must not only stop the harm caused by drugs: let's unleash the capacity of drugs to do good.

You think this is a radical idea? Look back to the origins of drug control. The Preamble of the Single Convention recognizes that … the medical use of narcotic drugs continues to be indispensable for the relief of pain… This is hardly the language of a prohibitionist regime.

Indeed, this noble goal of UN drug policy, the freedom from physical pain, demonstrates our over-riding commitment to health."

Antonio Costa, Exec Director,
UN Office on Drugs and Crime (UNODC)
March 2010