International Association for the Study of Pain
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International Association for the Study of Pain
Task Force on Wait-Times
SUMMARY AND RECOMMENDATIONS

Background

It is established that patients suffering with chronic pain deteriorate while waiting for treatment. The deterioration includes escalating pain and depression and decreased health-related quality of life (Lynch, Campbell et al. 2008). In addition, an international survey of IASP Presidents and other key informants has identified that problems with wait-times for appropriate service or with lack of access to service occur in many nations (Lynch, Campbell et al. 2007).

On October 11, 2004, during the first Global Day Against Pain, IASP joined with the World Health Organization and the European Federation of IASP Chapters in calling for pain control to be recognized as a major public health issue and a human right (Bond and Breivik 2004; Brennan and Cousins 2004). In keeping with the IASP guiding principle that all peoples have a right to treatment of their pain, patients should receive timely access to appropriate care for chronic pain.

To address this problem, it will be necessary to advocate strongly with health care funders and governments who look to health care specialists and the literature for guidance. We believe there are two steps necessary to accomplish this goal:

- Identify appropriate wait-times benchmarks for treatment of chronic pain and produce a document endorsed by IASP.
- Support and pursue multi-national initiatives to address timely and appropriate treatment for the management of chronic pain.

In an effort to begin to address this problem, the IASP President established a Task Force in January 2009 to identify benchmarks to address the first of these two steps.

The Task Force completed an international environmental scan which identified several nations where rigorous initiatives have established guidance or benchmarking documents regarding the issue of wait times for management of chronic pain. These included Australia, Canada, Finland, Norway and the United Kingdom. A summary of the Benchmarks recommended by each of these countries appears in Table 1.

In summary, Finland, Norway and Western Australia (with the rest of Australia likely to follow) lead the world with regard to government mandated guidelines specific for wait-times for treatment of chronic pain. There is significant congruence in the guidelines across nations. The Task Force members have reviewed and synthesized the information and propose the following recommendations.

Recommendation for Wait-times:

- **Most urgent (1 week):** acute painful severe condition with risk of deterioration or chronicity (new CRPS) or pain related to cancer or terminal or end stage illness (acute herpes zoster also requires urgent treatment but ideally should be treated at the primary care level rather than requiring a pain specialist service).
- **Urgent or semi-urgent (1 month):** severe undiagnosed or progressive pain and risk of increasing functional impairment generally 6 months duration or less (back pain not resolving, neuropathic pain, post surgical or post traumatic pain)
- **Routine or regular (4 months):** persistent long-term pain without significant progression

Additional Recommendations:

1. Given the serious problem with lack of access to treatment in the developing world and in rural or remote areas or marginalized populations in other countries, it is recommended that IASP proceed with the second step noted above and support multi-national initiatives to build capacity to provide timely and appropriate treatment for the management of pain both acute and chronic.
2. In proceeding with this second step it will be necessary to:
    - Address quality control. At present there is wide variation in the nature of care; standards of care need to be developed and adopted or endorsed where good standards exist. At present IASP provides an excellent document for development of clinical practice guidelines. The IASP recommendations for Pain Treatment Services identifies that clinicians should be aware of all relevant treatment guidelines but it stops there. Guidelines are needed for many key conditions (e.g. low back pain, headache, complex regional pain syndrome, surgical/post-surgical pain, chronic visceral pain, fibromyalgia). The American Pain Society appears to have made the most progress in this area (http://www.ampainsoc.org/pub/cp_guidelines.htm). IASP should provide guidance on this issue.
    - Build capacity for cost effective appropriate treatment of pain including:
        - Support chronic disease self-management approaches in chronic pain treatment (LeFort, Gray-Donald et al. 1998; Lorig and Holman 2003; Lorig, Ritter et al. 2005; McGillion, Watt-Watson et al. 2007)
        - Facilitate initiatives to improve education of community and primary care practitioners regarding management of pain
        - Encourage/enhance/facilitate consultation networks between professionals (e.g. tele-health, electronic)
        - Support initiatives to increase multidisciplinary teams for pain treatment
        - Develop pathways of care for referral through primary, secondary and tertiary levels of care, to assure the most appropriate and efficient use of limited resources.
        - Pursue strategies to address/limit re-referral rates of patients with chronic pain where status remains unchanged, i.e. “end-point”.

Much of this work will have to be done by IASP members in their own nations. Indeed much excellent work has been done but there is a role for IASP in coordinating the collaboration of nations who have taken the lead as well as assuring dissemination of this knowledge and experience internationally. There is also a role for IASP in continued advocacy for initiatives to get resources for pain treatment to un-serviced populations. IASP has an excellent track record of advocacy with campaigns such as global day against pain and educational initiatives through the IASP Developing Countries Working Group. IASP is especially needed now as we move forward on the service delivery mandate. For this we will need to continue our work of convincing governments and other health care funding bodies that timely and appropriate treatment of pain is a human right and it is cost effective.

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References

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Table 1
Wait-times benchmarks for pain in countries that have them

	Most urgent	Urgent or semi-urgent	Routine or regular	Comments
Australia (from Department of Health Western Australia)	"immmediate" "category 1" **1 week** for acute, painful severe condition with risk deterioration and impairment quality of life (eg. cancer, new CRPS, acute zoster)	"urgent" "category 2" **1 month** painful condition with intermediate duration and progressionand risk of increasing functional impairment (eg. acute back pain becoming chronic)	"routine" "category 3" **3 months** persistent long term pain, rapid progression unlikely, maintenance treatment started or review/reassessment have become necessary(eg.PHN, chronic LBP, persistent pain, long term opioid use requiring renewal of authorization)	It is acknowledged that the routine waitlist in WA is currently 12 months due to limited facilities, they are extending authorizations if a referral has been initiated
Canada Wait Times Alliance Recommendations published November 2007	**14 days** cancer pain	**30 days** Acute neuropathic pain of less than 6 months	**3 months** for acute lumbar disc protrusion or subacute chronic pain in an adult of working age where intervention may improve function	6 months for other types of chronic pain
UK Government mandated			**18 weeks** wait from referral to treatment for all conditions in outpatient clinics	These are generic guidelines and not specific to pain
Finland Government mandated	**1 month** for severe undiagnosed pain or prolonged post traumatic or post surgical pain	**3 months** for moderate undiagnosed pain	**6 months** for non-urgent care of chronic pain	In Finland this government mandated access to health care was extended to chronic pain in March 2007.
Norway* Guidelines published by the Norwegian Directorate of Health June 2009	**2 weeks** **"Group1** or subacute pain conditions" that have lasted more than 6 months and may develop into difficult to treat pain "**Group5** or severe and difficult to treat pain in known serious and advanced illness (eg. cancer, heart failure, end stage MS etc.)	**16 weeks** **"Group 2** or chronic complex pain with or without known initiating cause and no longer curable and co-morbid problematic drug use or psychiatric illness	**16 weeks** **Group 3** or Chronic complex pain with known initiating cause no longer curable **"Group 4** or chronic complex pain condition without known initiating cause	These wait times apply to those deemed to have a legal right to treatment‡

***In Norway: waiting time is time from evaluation (triage into one of 5 groups) of application from primary care physician (which must take place within 30 days) to medical treatment.**