Next steps in access and availability of opioids for the treatment of cancer pain: reaching the tipping point?

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The reports of the Global Opioid Policy Initiative (GOPI) project to evaluate the availability and accessibility of opioids for the management of cancer pain in Africa, Asia, Latin America and the Caribbean, and the Middle East, together with the previous 2010 European Society for Medical Oncology (ESMO)/European Association for Palliative Care (EAPC) report from Europe, have provided critical data in demonstrating the deficiencies in many countries throughout the world. Formulary deficiencies and over-regulation are pandemic and must be addressed. This process is challenging and will require concerted and sustained efforts by clinical leaders and advocacy groups partnering with international and regional organizations and, of course, with national governments and their competent authorities. There is a growing international expertise and infrastructure to coordinate advocacy and strategic planning based on the World Health Organization (WHO) Model of Education, Policy Reform and Medication Availability.

**introduction**

‘The use of controlled substance should be limited to medical and scientific purposes while preventing their abuse misuse and diversion.’—The Single Convention of Narcotic Drugs (1961) (ref).

The Single Convention, the world’s guiding document on the use of controlled substances, goes on to state that opioids are essential for the relief of pain. Critically, the Convention does not state that the use of controlled substances should be limited to medical and scientific purposes, only limited to their medically defined use. However, the limitation of the use of opioids for medical and scientific purposes has been much of the reality of the Single Convention’s implementation for over 50 years.

An increase in opioid consumption has been seen throughout the world in the last 30 years, but little of this increase has occurred in low- and middle-income countries (LMICs) (Figure 1). Many have highlighted the extent of this global discrepancy [1–4]. Cherny et al. (2010) described many of the formulary and regulatory reasons for the difference in opioid consumption for cancer pain management between Eastern and Western Europe [5]. This 2013 volume now contains documentation of the formulary and regulatory reasons for low opioid consumption for Africa [6], Asia [7], India [8] Latin America and the Caribbean [9], and the Middle East [10]. The combined data for all these regions are illustrated graphically for formulary availability (Figure 2) and regulatory barriers (Figure 3). Most of the world’s population lacks the necessary access to opioids for cancer pain management and palliative care, as well as acute, post-operative, obstetric and chronic non-cancer pain.

One could draw a pessimistic view that little progress has been made in LMICs. But progress has been and continues to be made in many countries as documented by the International Narcotic Control Board (INCB, 2010) and from Duthey and Scholten, 2013 [4]. Sixty-seven countries showed a >10% increase in opioid consumption between 2006 and 2010 as measured by %ACM (percentage of Adequacy of Consumption Measure). While a smaller number had a decrease in %ACM and other nations still fail to report their consumption to the INCB, the global community may be approaching a ‘tipping point’ in terms of improving access to opioids for medical and scientific purposes. What evidence do we have for this?

**the commission on narcotic drugs**

The Commission on Narcotic Drugs (CNDs) is a United Nations body established in 1946 to assist in supervising the application of the international drug control treaties. In 1991, the United Nations General Assembly (UNGA) further expanded the mandates of the CND to enable it to function as the governing body of the United Nations Office on Drugs and Crime (UNODC).

In recent years, the CND has passed resolutions addressing the lack of access to opioids for the relief of pain. Resolutions express concern about the low level of the use of opioids for medical purposes and call on nations to identify means of improving this (http://daccess-dds-ny.un.org/doc/UNDOC/LTD/V11/815/54/PDF/V1181554.pdf?OpenElement).
Figure 1. Comparison of opioid consumption (mg/capita) in morphine equivalence without methadone. SEARO = South East Asia, WPRO = Western Pacific, AFRO = Africa, AMORO-North America = Latin America and Caribbean (America not including North America), EMRO = Middle East (Eastern Mediterranean).

Figure 2. Summary map for formulary availability (not actual availability) of the seven essential opioid formulations of the International Association for Hospice and Palliative Care (IAHPC).
Furthermore, the UNGA in its special session on Non-Communicable Disease's (NCDs) in New York, in 2011, included palliative care as an important health system issue that needs to be addressed in dealing with NCDs.

**The World Health Organization**

The World Health Organization (WHO) has been charged with implementing a Global Monitoring Framework for NCDs and has determined a surrogate indicator to measure the progress in palliative care. This NCD indicator will be opioid consumption measured as morphine equivalents of opioids (excluding methadone) consumed per cancer death. Using data collected by the INCB, this process adds to ongoing work within the WHO to promote palliative care as a means to reduce suffering caused by NCDs. Although the targets and indicators of the Global Action Plan on the Prevention and Control of NCDs 2013–2020 are voluntary, and therefore not binding on any nation, the inclusion marks a significant global acknowledgement of the need to improve access to palliative care.

While recognizing that this indicator is a surrogate and neither a perfect nor a direct measure, it is an objective and measurable indicator that reflects progress in palliative care interventions, without the need for initiating a new large scale and potentially costly data collection. The data included in these reports are opioid consumption measured as morphine equivalents of opioids consumed per person, a measure used by the Pain and Policy Studies Group (PPSG). The WHO has proposed this metric as a Universal Health Care Indicator for Palliative Care.

World Health Organization. WHO Model List of Essential Medicines 18th ed. Geneva: World Medical Association 2013. (http://www.who.int/medicines/publications/essentialmedicines/18th_EML_Final_web_8Jul13.pdf). The WHO also continues to address palliative care with seven collaborating centers that specifically address palliative care in their terms of reference. Furthermore, in 2014, the WHO Secretariat has been requested by Member States to bring to the World Health Assembly a resolution that lays out the importance of palliative care and appropriate access to opioids in public health. A dedicated resolution has the promise to set out a road map for the international community to improve availability and access to palliative care services.

**The role of regional organizations**

While each nation will have responsibility for improving palliative care services for its residents, there is increasing potential for the influence of regional government...
organizations. Ministers of Health and other ministry representatives of 15 African counties recently met in South Africa and strongly supported improving the availability of palliative care throughout their region. This meeting, that also addressed issues of opioid availability, preceded the combined meeting of the African Palliative Care Association (APCA) and the Hospice and Palliative Care Association of South Africa. The engagement with international and regional organizations within Civil Society (Table 1) can provide powerful support for advocacy with national regulatory authorities.

**the role of individual governments**

The information provided in this supplement advances the previous work of Cherny et al. [5] for Europe. The reports of this volume for the States of India and the regions of Africa, Asia, the Middle East, Latin America and the Caribbean provide critical substrate data for the evaluation of regulatory policies that may be undermining opioid availability for the management of cancer pain. While the call has come out for improvement in opioid availability from global and regional organizations, the responsibility for this improvement ultimately lies with each nation’s government.

It is incumbent upon responsible individual governments to evaluate their regulatory structures for over-regulation and to undertake the necessary legislative and regulatory reforms to ensure accessibility to essential pain relieving medications.

This approach is illustrated in the case study of the Ukraine which was highlighted in the European report [5] for its limited opioid formulary (only injectable morphine) and which can now be commended as a nation making progress. Concerted efforts supported by the Open Society Institute, reports from Human Rights Watch [11], together with the investment in local clinical champions through programs such as the PPSG’s International Pain Policy Fellowship (IPPF) Program [12], have led to the government approving the manufacture and distribution of immediate-release oral morphine in the Ukraine with concurrent changes in policy. No longer should Ukrainians like Vlad, a young man with an inoperable brain tumor, or Artur, a former KGB colonel with metastatic prostate cancer, whose stories were so shockingly displayed in reports [11] and documentaries [12], have to endure the severe pain caused by their cancers. The national data derived from the European Society for Medical Oncology (ESMO); and the European Association for Palliative Care (EAPC) survey provided for Eastern Europe was not the only tool used to bring about change in the Ukraine, but it proved to be an important tool to drive much education and advocacy throughout Europe to improve opioid availability.

**the cornerstone trinity: medication availability, education, and policy reform**

Once a nation’s government has determined that it can and is ready to make necessary changes, the global community is ready and willing to support these efforts. But the efforts for change have to span the cornerstone trinity and be directed at medication availability, education, and policy reform. The checklist provided in the WHO policy guidelines, *Ensuring Balance in National Policies on Controlled Substances, Guidance for availability and accessibility of controlled medicines*, is a useful initial tool [13]. Furthermore, review of legislation and comparison with model laws that have just been updated by the UNODC, together with a parallel review of regulations, are an important part of the process.

India’s Narcotic Drugs and Psychotropic Substances (NDPS) Act is a prime example of this. The amendment that is currently before the Federal Parliament was crafted through the collaboration of the India Government’s Departments of Revenue and Health and Family Services with many organizations, including the Indian Association of Palliative Care, the two WHO Collaborating Centers in India addressing palliative care, and the PPSG with three IPPF awardees supported by the Livestrong Foundation. The Human Rights Watch report on the lack of availability of opioids provided significant stimulus for action, as did coverage in both mainstream and social media [14]. The global palliative care community is watching the winter session of the Indian Parliament for the successful passing of this amendment.

Many of the impactful solutions do not require major changes in law. IPPF awardees in Jamaica collaborated with the ‘Competent Authority’, specifically the Office of Dangerous Drugs in the Ministry of Health. Simple dialog with advocates was sufficient to inform and activate the needed change in the tone and focus of regulatory activity. The Ministry of Health issued a press release highlighting this refocus: ‘Pain management and palliative care must address patient and family discomfort and restore persons to their productivity level. It is important that we understand new methods of pain management and prevent misuse. Opioids are important and

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**Table 1. International and Regional Civil Society Organizations with a focus on palliative care**

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<thead>
<tr>
<th>International</th>
<th>Regional</th>
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<tr>
<td>UlCC’s Global Access to Pain Relief Initiative (GAPRI)</td>
<td>European Association for Palliative Care (EAPC)</td>
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<tr>
<td>International Association for Hospice and Palliative Care (IAHPC)</td>
<td>European Society for Medical Oncology (ESMO)</td>
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<tr>
<td>Pain and Policy Studies Group, University of Wisconsin Carbon Cancer Center (PPSG)</td>
<td>African Palliative Care Association (APCA)</td>
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<td>Worldwide Palliative Care Alliance (WPCA)</td>
<td>African Organization for Research and Training in Cancer (AORTIC)</td>
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<td>International Association for the Study of Pain</td>
<td>Asian Pacific Hospice and Palliative Care Network (APHIN)</td>
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<td>International Children’s Palliative Care Network</td>
<td>Middle East Cancer Consortium (MECC)</td>
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<tr>
<td>International Palliative Care Initiative (IPCI) of the Open Society Foundation (OSF)</td>
<td>Latin American Palliative Care Association (ALCP)</td>
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<tr>
<td>Multinational Association of Supportive Care in Cancer (MASCC)</td>
<td>Latin American and Caribbean Society for Medical Oncology (SLACOM)</td>
</tr>
<tr>
<td>International Network for Cancer Treatment and Research (INCTR)</td>
<td>SAARC Federation of Oncology (SFO)</td>
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effective and we have to examine the policies and legal framework surrounding their use, as we may need to adjust them to allow us greater flexibility and protect the health worker.’

the collaborative approach

Champions within a country should not be concerned about disclosure of civil society collaborators for fear of losing financial support. While it can be argued strongly that there is never enough philanthropic support for these efforts, it continues to be a priority for a number of funders. The new global and political awareness described above will hopefully encourage engagement from new global philanthropic organizations and bilateral donors to provide the funds to scale up successful models in more countries.

In the past, it has often been easier for individual associations, NGO’s, and philanthropic organizations to work independently within a country. A coordinated approach, harnessing the expertise and synergies of leaders across the fields of public health, palliative care, pain management, education, regulation, and law is necessary to create a united voice and achieve the ‘tipping point’ for a real change and sustained impact. The Union for International Cancer Control, through the ‘Global Access to Pain Relief Initiative—GAPRI’ (www.uicc.org/programmes/gapri), aims to take on this convening role. Similarly, the International Association for Hospice and Palliative Care, in collaboration with the European Association for Palliative Care and other partners, have initiated the Prague Charter, urging governments to ensure access to palliative care and essential pain relief medicines for all patients in need [15].

There should be great optimism that, through collaboration and united efforts of the leading palliative care and oncology organizations who participated in this report, many of the formulary and regulatory issues related to the difference in opioid consumption at regional and national levels can be overcome. It may be that with the recognition of this problem by the World’s governing bodies, we reach our ideal goal in ensuring adequate access to affordable and effective pain medications for all cancer patients.

references