



Overview of The *Lancet* Commission Report: Alleviating the access abyss in palliative care and pain relief – an imperative of universal health coverage

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“Serious health-related suffering is a massive, appalling oversight in global health that must be remedied. Palliative care and pain relief are some of the most neglected dimensions of global health today.”¹

Palliative care and pain relief, despite being essential elements of Universal Health Coverage, have been largely ignored in global health. This report by the *Lancet* Commission on Global Access to Palliative Care and Pain Relief,¹ a multidisciplinary team of 35 commissioners co-chaired by Dr. Felicia Knaul and Dr. Paul Farmer, addresses the following:

1. **Burden:** Conceptualizes a new framework to measure the burden of **serious health-related suffering (SHS)**, associated with illness or injury of any kind, that could be alleviated by palliative care or pain treatment
2. **Unmet Need:** Demonstrates most of the SHS caused by unrelieved pain is untreated, resulting in a **global pain divide**;
3. **Response:** Defines an **Essential Package** of palliative care and pain relief medicines, human resources and equipment that can be delivered at all levels of care to alleviate most of the SHS;
4. **Affordability:** Costs the Essential Package by income group, and the amount of morphine required to close the global pain divide using best international reported medicine prices;
5. **Integration:** Outlines global and national **health-systems strategies** to expand access to palliative care and pain relief as an integral component of **Universal Health Coverage (UHC)** while minimizing the risk of non-medical use

The Commission established an **Implementation Working Group** of leaders from global, national, and regional palliative care advocacy institutions to take forward the recommendations in the report. The group is led in partnership with the **International Association for Hospice and Palliative Care (IAHPC)**, and provides a platform to foster collaborative progress, facilitate and inform advocacy, and ensure accountability in global access to palliative care and pain relief.

1. BURDEN: Each year more than 61 million people experience serious health-related suffering (SHS). Over 80% of these people live in low- and middle-income countries where palliative care and pain relief is scarce or non-existent.

The Commission developed a new framework for measuring the global burden of SHS across 20 life-limiting and life-threatening conditions most associated with a need for palliative care, and 15 associated physical and psychological symptoms. Using this framework, the Commission quantified the staggering global burden of SHS for the first time. More than 61 million people each year experience SHS that could be ameliorated by palliative care and pain relief. These individuals suffer at least 6 billion physical and psychological symptom days each year. Over 80% of this SHS burden occurs in low- and middle-income countries (LMICs) where access to palliative care, even oral immediate-release morphine for pain relief, is extremely limited. Every year almost 2.5 million children die with SHS and more than 98% of these children are from LMICs. A large proportion of the current SHS burden is associated with non-communicable chronic diseases (NCDs) such as cancer, dementia, cerebrovascular disease, and lung disease, and this will only increase as populations age. Globally, approximately 15 million cancer patients alone experience SHS every year.

Existing health metrics focus on prolonging life and productivity, while largely ignoring human suffering. As such, priority-setting for health does not take into account the burden of health-related suffering that could be ameliorated by palliative care. This new measure of SHS, and the massive scale of human suffering that it uncovered, stresses the enormous need for palliative care and pain relief in our world.

¹ Knaul FM, Farmer PE, Krakauer EL et al on Behalf of the Lancet Commission on Palliative Care and Pain Relief Study Group. Alleviating the access abyss in palliative care and pain relief—an imperative of universal health coverage: The Lancet Commission report. *The Lancet*. 2017. <http://www.thelancet.com/commissions/palliative-care>

2. UNMET NEET: Off-patent immediate-release oral and injectable morphine for pain relief is critical to palliative care, inexpensive and effective, yet most of the world lacks sufficient access.

The report uncovered one of the starkest and most inequitable distributions in global health today. Immediate-release oral and injectable morphine are critical to palliative care: it is inexpensive and effective and yet patients in 128 countries lack sufficient access (*Figure 1*). While countries such as the United States, Australia, and Canada receive upwards of 40,000 mg of distributed opioid morphine-equivalent (DOME) per patient in need of palliative care, patients in countries such as Nigeria and Haiti receive less than 1 mg of DOME, meeting less than 1% of their palliative care needs for pain relief. This has resulted in a global pain divide, what the Commission considers the core of the “access abyss”, where 50% of the world’s population – the poorest half – have access to less than 1% of DOME, leaving most of the world devoid of the necessary medications to ameliorate avoidable pain and suffering. Even in countries where DOME is significantly high, people who are in need of pain medication are often denied access due in part to growing opiophobia – prejudice and misinformation on medical use of opioids – amongst policy makers and providers, making access to palliative care and pain relief a worldwide crisis. Rational and balanced policies which ensure appropriate consideration of both the medical need for opioids and the risk of non-medical use are lacking in many parts of the world.

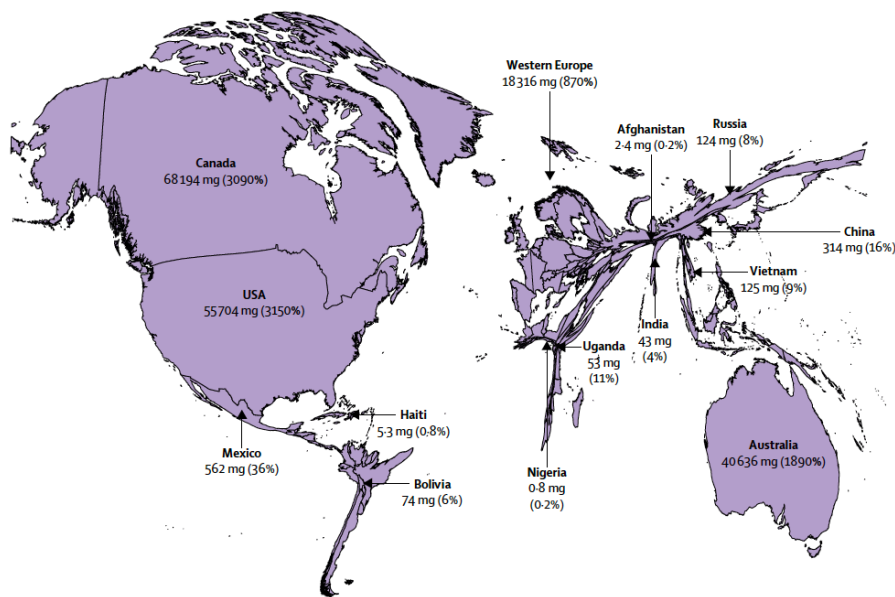


Figure 1. Map of access to distributed opioid morphine-equivalent (DOME); Numbers indicate morphine in mg/patient in need of palliative care, average 2010–13, and estimated percentage of need that is met for the health conditions most associated with serious health-related suffering.

3. RESPONSE: An affordable, Essential Package of palliative care and pain relief interventions can ameliorate a large part of the preventable burden of SHS.

The Commission’s expert panel of palliative care providers determined that much of the SHS burden could be alleviated with health services that can be made accessible to people worldwide. They developed an Essential Package that is the minimum a health system, however resource-constrained, should make universally accessible (*Figure 2*). The Essential Package contains the inputs for safe and effective palliative care and pain relief for both adults and children, including the medicines (largely based on the WHO model list of essential medicines), doses, and administration routes. Its medicines and equipment can all be safely prescribed or administered in a primary care setting where health professionals have received basic training in palliative care.

The Essential Package of Palliative Care and Pain Relief		
Medicine	Medical Equipment	Human Resources
Amitriptyline	Pressure-reducing mattress	Doctors (specialty and general)
Bisacodyl (Senna)	Nasogastric drainage or feeding tube	Nurses (specialty and general)
Dexamethasone	Urinary catheters	Social workers and counsellors
Diazepam	Opioid lock box	Psychiatrist, psychologist, or counsellor
Diphenhydramine (chlorpheniramine, cyclizine, dimenhydrinate)	Flashlight with rechargeable battery	Physical therapist
Fluconazole	Adult diapers / cotton and plastic	Pharmacist
Fluoxetine or other SSRI (sertraline and citalopram)	Oxygen	Community health workers
Furosemide		Clinical support staff
Hyoscine butylbromide		Non clinical support staff
Haloperidol		
Ibuprofen (naproxen, diclofenac, meloxicam)		
Lactulose (sorbitol or polyethylene glycol)		
Loperamide		
Metoclopramide		
Metronidazole		
Morphine (oral immediate-release and injectable)		
Naloxone Parenteral		
Omeprazole oral		
Ondasetron		
Paracetamol oral		
Petroleum jelly		

Figure 2. List of Essential Package medicines, medical equipment, and human resources.

The Essential Package is the lowest possible cost by design. This was achieved by including only off-patent medicines, using frugal innovation for the included equipment, and applying a staffing model based on competencies rather than professions. To further bolster human resources, the Report recommends training all health professionals at all levels of care on basic palliative care competencies, which can be supported through global standardized curricula and clinical guidelines.

4. AFFORDABILITY: At best international medicine prices, approximately US\$145 million per year would pay for the world's unmet need for morphine in palliative care.

The Essential Package for palliative care and pain relief developed by the Commission is one of the least costly components that form the essential UHC package proposed by Disease Control Priorities (DCP, 3rd edition).² For low-income countries, the Essential Package costs about US\$2.16 per capita per year at lowest reported international medicine prices, which is about 3% of the cost of the essential UHC package. In LMICs, the cost is \$0.78 per capita per year, which is 0.6% of the cost of the essential UHC package, and just over 1% of total LMIC per capita health expenditure.

The Commission estimates that the cost of meeting the world's unmet need for morphine for palliative care is only \$145 million per year if all countries had access to the lowest reported retail prices paid by some high-income countries. However, prices paid by countries for medicines, especially injectable morphine, vary enormously. The Commission found substantial potential savings if countries could access best-case international medicine prices; for example, access to best international prices would reduce overall costs of the Essential Package for low-income countries by about 25%. For low-income countries, the cost of meeting the shortfall in morphine is only \$13 million per year at lowest retail prices (\$69 million per year at current prices). The cost to cover morphine-equivalent pain treatment for all children younger than 15 years with SHS in low-income countries is just \$1 million per year.

The Report highlights how access to palliative care can result in cost-savings for the health system by reducing costly end-of-life hospital admissions. While more research is required, these savings may offset the cost of universal access to the Essential Package in many countries. More so, access to palliative care and pain relief can reduce the risk of impoverishment and strengthen health systems by addressing priorities related to palliative care interventions while simultaneously investing in the overall health system that benefits the population at large.

5. INTEGRATION: Expanding access to palliative care is an integral component of UHC, which offers a key opportunity to improve the welfare of the poor.

Universal access to the Essential Package, especially off-patent, oral immediate-release and injectable morphine, offers an opportunity to alleviate unnecessary SHS for the approximately 61 million individuals afflicted by SHS annually. This will require the integration of palliative care as a core component of UHC, which is necessary for countries to meet **Sustainable Development Goal (SDG) Target 3.8**.

Universal access to palliative care will require overall health system strengthening through multisectoral **stewardship** of national palliative care plans, regulation, monitoring, and advocacy; integrated and organized **financing** schemes; equitable, comprehensive, and safe health system **delivery** mechanisms; commitment to the **resource generation** of palliative medical professionals; and effective management of timely and reliable **information and research** (*Figure 3*). All countries should make the Essential Package accessible by 2030.

Stewardship of palliative care must be intersectoral and interinstitutional. Countries and responsible global entities must ensure a balanced approach to maximize access to morphine for medical and scientific use while minimizing the risk of non-medical use. Countries that report high consumption of opioids and little or no non-medical use must disseminate lessons learned and best practices. In most LMICs, unduly restrictive laws and regulations hinder the availability of and access to opioids for people with legitimate needs. Yet there is reason to assume that the diversion and nonmedical use of drugs is not a function of increasing medical access in LMICs, but rather a consequence of inadequate safeguards to minimize such diversion in certain high-income countries. Some of the recommendations for implementing this **balanced approach** include: sound national estimates of the need for pain relief medication that take into account the system capacity to ensure a safe supply chain; robust monitoring systems that track under- or over-supply of distributed opioids; strong conflict-of-interest policies that restrict and regulate the marketing of opioids, especially to health professionals; and adequate training of all health professionals on palliative care and pain relief administration.

² Cleary J, Gelband H, Wagner J. Cancer pain relief. In: Gelband H, Jha P, Sankaranarayanan R, Horton S, eds. Disease Control Priorities in Developing Countries, 3rd edn. Washington, DC: The International Bank for Reconstruction and Development, The World Bank; New York, NY: Oxford University Press, 2006.

Strengthening health-systems functions to expand access to palliative care and pain relief	
<p>Stewardship</p> <p><i>Priority setting</i></p> <ul style="list-style-type: none"> • Implement public education and awareness-building campaigns around palliative care and pain relief • Incorporate palliative care and pain relief into the national health agenda <p><i>Planning</i></p> <ul style="list-style-type: none"> • Develop comprehensive palliative care and pain relief guidelines, programs, and plans • Integrate palliative care into disease-specific national guidelines, programs, and plans • Include palliative care and pain relief essential medicines in national essential lists <p><i>Regulation</i></p> <ul style="list-style-type: none"> • Establish effective legal and regulatory guidelines for the safe management of opioid analgesics and other controlled medicines that do not generate unduly restrictive barriers for patients • Design integrated guidelines for provision of palliative care and pain relief that encompass all services providers <p><i>Monitoring and evaluation of performance</i></p> <ul style="list-style-type: none"> • Monitor and evaluate palliative care and pain relief interventions and programs using an explicit outcomes scale, measuring coverage as well as effect • Promote civil society involvement in performance assessment <p><i>Intersectoral advocacy</i></p> <ul style="list-style-type: none"> • Engage all relevant actors in the promotion and implementation of palliative care interventions and programs through ministries of health <p>Information and research</p> <ul style="list-style-type: none"> • Incorporate palliative care and pain relief access, quality, and financing indicators into health information systems • Ensure that government-funded research programs include palliative care 	<p>Financing</p> <ul style="list-style-type: none"> • Explicitly include palliative care interventions in national insurance and social security health-care packages • Guarantee public or publicly mandated funding through sufficient and specific budgetary allocations starting with the Essential Package • Develop pooled purchasing schemes to ensure affordable, competitive prices for palliative care inputs and interventions <p>Delivery</p> <ul style="list-style-type: none"> • Integrate palliative care and pain relief at all levels of care and in disease-specific programs • Design guidelines to provide effective and responsive palliative care and pain relief services • Integrate pain relief into platforms of care, especially surgery • Establish efficient referral mechanisms • Implement quality-improvement measures in palliative care initiatives • Develop and implement secure opioid supply chain and ensure adequate prescription practices <p>Resource generation</p> <p><i>Human Resources</i></p> <ul style="list-style-type: none"> • Establish palliative care as a recognized medical and nursing specialty • Make general palliative care and pain relief competencies a mandatory component of all medicine, nursing, psychology, social work, and pharmacy undergraduate curricula • Require that all health and other professionals involved in caring for patients with serious, complex, or life-threatening health conditions receive basic training in palliative care and pain relief

Figure 3. Strengthening national health system functions to expand access to palliative care and pain relief.

To achieve universal access to palliative care and pain relief, global health institutions must become adept at promoting and facilitating effective action by countries. Numerous opportunities exist for establishing synergistic agendas with common causes such as NCDs, SDGs and UHC to undertake collective action, spearheaded by actors such as WHO, development banks, and international civil society groups. **Global collective action** should be focused on four core functions:

1. International stewardship for the development and implementation of accountability mechanisms;
2. Production of global public goods, especially knowledge-related goods such as guidelines and indicators to assist with the progress towards universal palliative care;
3. Management of externalities through the exchange of lessons learned and best practices; and
4. Mobilization of global solidarity and convening to support each country's efforts towards universal palliative care, and to continue the movement that prioritizes palliative care as indispensable to UHC and fundamental to medical care.

The Commission calls for ongoing advocacy, accountability, and analysis to close the access abyss in palliative care and pain relief.

Closing the access abyss requires strong metrics and data to track global and national progress towards universal palliative care coverage and empower advocacy efforts to ensure accountability. To meet this agenda, in partnership with the IAHP, the Commission established an **Implementation Working Group** of civil society leaders from palliative care advocacy institutions to work alongside Commission researchers in the following four streams of work:

1. **Research** to develop monitoring frameworks and public accountability tools, including indicators and targets that can be adapted and adopted by both countries and global governance institutions;
2. **Advocacy and awareness-building** to translate and disseminate the knowledge generated by the Commission, and encourage the production and dissemination of knowledge from implementation, especially in LMICs
3. **In-country implementation** to support national commissions through training and capacity building; catalyze national planning for palliative care and pain relief;
4. **Global collective action** to forge linkages with other synergistic movements like NCDs, SDGs, UHC.

The critical mass gathered at the global launch symposium of the Commission Report in April of 2018 drafted and published the Miami DeclarAction,³ an action statement (available through the Lancet website) documenting commitments by researchers and civil society members to address the access abyss in palliative care and pain relief. Additional resources including an advocacy toolkit with factsheets, country-specific policy briefs and data sheet, a video presentation of the findings of the Report, and a wall map are available under “background resources” at: www.miami.edu/lancet. Further resources can be found at hospicecare.com.

³ Knaul FM, Bhadelia A, Horton R. Health-related suffering: from Lancet Commission to DeclarAction. Lancet 2018; published online May 18. [http://dx.doi.org/10.1016/S0140-6736\(18\)31123-1](http://dx.doi.org/10.1016/S0140-6736(18)31123-1).