WHO PROPOSED PALLIATIVE CARE INDICATOR FOR THE GLOBAL MONITORING FRAMEWORK ON PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES

In its discussion paper of March 22, 2012 on a global monitoring framework on the prevention and control of non-communicable diseases, the World Health Organization (WHO) proposed an indicator to measure access to palliative care. Our organizations strongly support the inclusion of a palliative indicator and believe that it can significantly contribute to the development of this health service worldwide. This paper contains observations about the proposed WHO indicator.

THE INDICATOR

In its discussion paper, the WHO proposes five indicators with voluntary targets (reductions in mortality from NCDs, hypertension, tobacco use, salt intake and physical inactivity) and 12 "other WHO core indicators" which do not have targets. Access to palliative care is included in this second set of indicators. The WHO states that access to palliative care will be "assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer."[1]
The non-methadone morphine equivalent value is used to to avoid distorting the calculations by the consumption of methadone for opioid substitution treatment.

The WHO does not provide details on how the indicator would be calculated.

ADVANTAGES OF THE INDICATOR

Every year, tens of millions of patients with non-communicable diseases require palliative care to relieve suffering or, when curative treatment is no longer an option, ensure the highest possible quality of life until death. Although the WHO considers palliative care an integral part of health services for many non-communicable diseases, the vast majority of these patients do not have access to palliative care and face great unnecessary suffering as a result.

In an effort to address this unnecessary suffering, the Political Declaration on Non Communicable Diseases (NCDs) that was agreed upon at the High Level Meeting discusses the need for palliative care for people with NCDs (see paragraph 45b, 45c, 45l and 55). Moreover, the current WHO Action Plan for the Global Strategy for the Prevention and Control of NCDs includes a commitment to measure the availability of palliative care. To date, however, United Nations agencies and member states have not systematically monitored the availability of palliative care.

This indicator would, for the first time, set up routine monitoring of a core component of palliative care, opioid consumption for pain treatment. Although the indicator is not linked to a

[1] http://www.who.int/nmh/events/2012/discussion_paper2_20120322.pdf

Union for International Cancer Control • Union Internationale Contre le Cancer
62 route de Frontenex • 1207 Geneva • Switzerland
Tel. +41 (0)22 809 1811 • Fax +41 (0)22 809 1810 • info@uicc.org • www.uicc.org
advocacy@uicc.org

target, it would allow tracking of progress on pain treatment over time; facilitate cross-country comparison; secure discussion of one of the components of palliative care in the follow-up meetings to the NCD Summit; generate discussion to develop additional palliative care indicators; raise awareness around this often neglected health service; and, hopefully, generate a sense of urgency for scaling up palliative care availability.

The proposed indicator measures a cornerstone of effective palliative care, the availability of treatment for moderate to severe chronic pain, per death from cancer. The Pain and Policy Studies Group, a WHO collaborating centre, and the Union for International Cancer Control use a similar indicator (although it also includes both cancer and HIV mortality).[2]

All the data required for the proposed indicator is already collected annually so it does not impose an additional burden on countries.

LIMITATIONS OF THE INDICATOR

While we strongly support the inclusion of an access to palliative care indicator in the global monitoring framework and feel that this is an appropriate proxy indicator that would measure access to one of the core components of palliative care, we would like to point out a number of important limitations:

- *Opioid consumption-based indicator.* The proposed indicator only considers the consumption of opioid analgesics as a measure of access to palliative care. As such, it does not take into consideration other intrinsic components of palliative care, such as treatment of physical symptoms other than pain, or psychosocial and spiritual support.

- *Not an adequacy indicator.* The proposed indicator does not provide a measure of the adequacy of palliative care in any given country, or of adequacy of consumption of strong opioid analgesics. It only provides data which may be used to track progress in countries and compare countries with each other.

- *Cancer-only indicator.* The proposed indicator provides a measure of consumption of strong opioid analgesics compared to cancer mortality. Significant numbers of patients with other major non-communicable diseases, such as diabetes, cardiovascular or lung disease, also require palliative care and access to opioid analgesics.

METHODOLOGY

The WHO discussion paper states that the access to palliative care indicator will be "assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer." It does not provide detail on data sources or exact methodology for calculating morphine equivalence.

The Pain and Policy Studies Group (PPSG), a WHO collaborating centre, and the Union for International Cancer Control Pain (UICC) use a similar indicator that draws on:

[2] Treat the Pain Campaign, Global Access to Pain Relief Initiative (GAPRI, UICC) http://www.treatthepain.com/worldwide-picture-untreated-pain

- Consumption data for narcotic drugs, including strong opioid analgesics, as reported by countries and published by the International Narcotics Control Board.

- WHO's estimates of the numbers of deaths from cancer, applied to updated population figures to produce annual estimates of the number of cancer deaths.

Morphine equivalent is a metric[3] to standardize doses of strong opioids and allows combination and comparison of different medicinal opioids. This equation is taken from the ratios of the defined daily dose (oral dosing for all except fentanyl, which is transdermal) as described by the WHO Collaborating Centre for Drug Statistics Methodology. [4]

PPSG and UICC use the non-methadone morphine equivalent value to describe opioid availability for pain relief.

Opioid consumption data are taken from the latest report of the International Narcotics Control Board (INCB) annual report for narcotics consumption. Where data are missing in the most recent report, values are taken from the INCB report for the previous year. For estimates that are reported as below ½ of the unit of measure, a value that is 0.25 of the unit of measure is used.
For each drug, the average of non-missing consumption data over the last 3 years is used to allow for variation between the years.

ALTERNATIVES

A number of alternatives could be considered to the current WHO proposal, including:

- An indicator based on the methodology used by the WHO Access to Controlled Medications Program in the Journal of Pain and Palliative Pharmacotherapy, which includes a broader spectrum of pain control, including not just patients needing chronic pain treatment but also acute pain (post-operative, trauma) and other chronic pain management needs.[5]

- The indicator used by PPSG and UICC, which calculates consumption of strong opioid analgesics per cancer and HIV mortality. The advantage of this indicator is that cancer and HIV are the two most prevalent causes of chronic moderate to severe pain and thus better captures epidemiological differences between countries.

- An indicator that calculates per capita consumption of strong opioid analgesics. Such indicator would not take into account epidemiological differences at all.

---

[3] Developed by the Pain and Policy Studies Group, University of Wisconsin
[4] WHO Collaborating Centre for Drug Statistics Methodology. ATC/DDD Index [Internet]. 2011 [cited 2011 Sep 16]. Available from: http://www.whocc.no/atc_ddd_index/
[5] *A First Comparison between the Consumption of and the Need for Opioid Analgesics at Country, Regional and Global Level* (Seya MJ, Gelders SFAM, Achara UA, Milani B, Scholten WK, J Pain and Palliative Care Pharmacotherapy, 2011; 25: 6-18).

- An indicator that calculates consumption of strong opioid analgesics per death from the four main non-communicable diseases.

CONCLUSION

Our organisations strongly support the inclusion of an access to palliative care indicator within the NCDs Monitoring Framework. While acknowledging the limitations, we believe that the indicator proposed by WHO is an effective way of measuring progress in availability of the treatment of chronic moderate to severe pain due to cancer, a core element of palliative care.

American Cancer Society
Human Rights Watch
International Association for Hospice and Palliative Care
Pain and Policy Studies Group, University of Wisconsin
Union for International Cancer Control
Worldwide Palliative Care Alliance

For further information, contact cmorris@thewpca.org. +44 (0)207 520 82 50