



SIP

Societal Impact of Pain

Proceedings

The SIP 2012 symposium took place under the high patronage of the Italian Presidency of the Council of Ministers and the Italian Ministry of Health.

The SIP 2012 symposium was hosted by the Danish Association for Chronic Pain Patients (FAKS). The scientific framework of SIP 2012 was under the responsibility of the European Federation of IASP® Chapters (EFIC®). The pharmaceutical company Grünenthal GmbH was responsible for funding and non-financial support (e.g. logistical support). The scientific aims of the SIP 2012 symposium have been endorsed by a large number of pain advocacy and scientific organisations.

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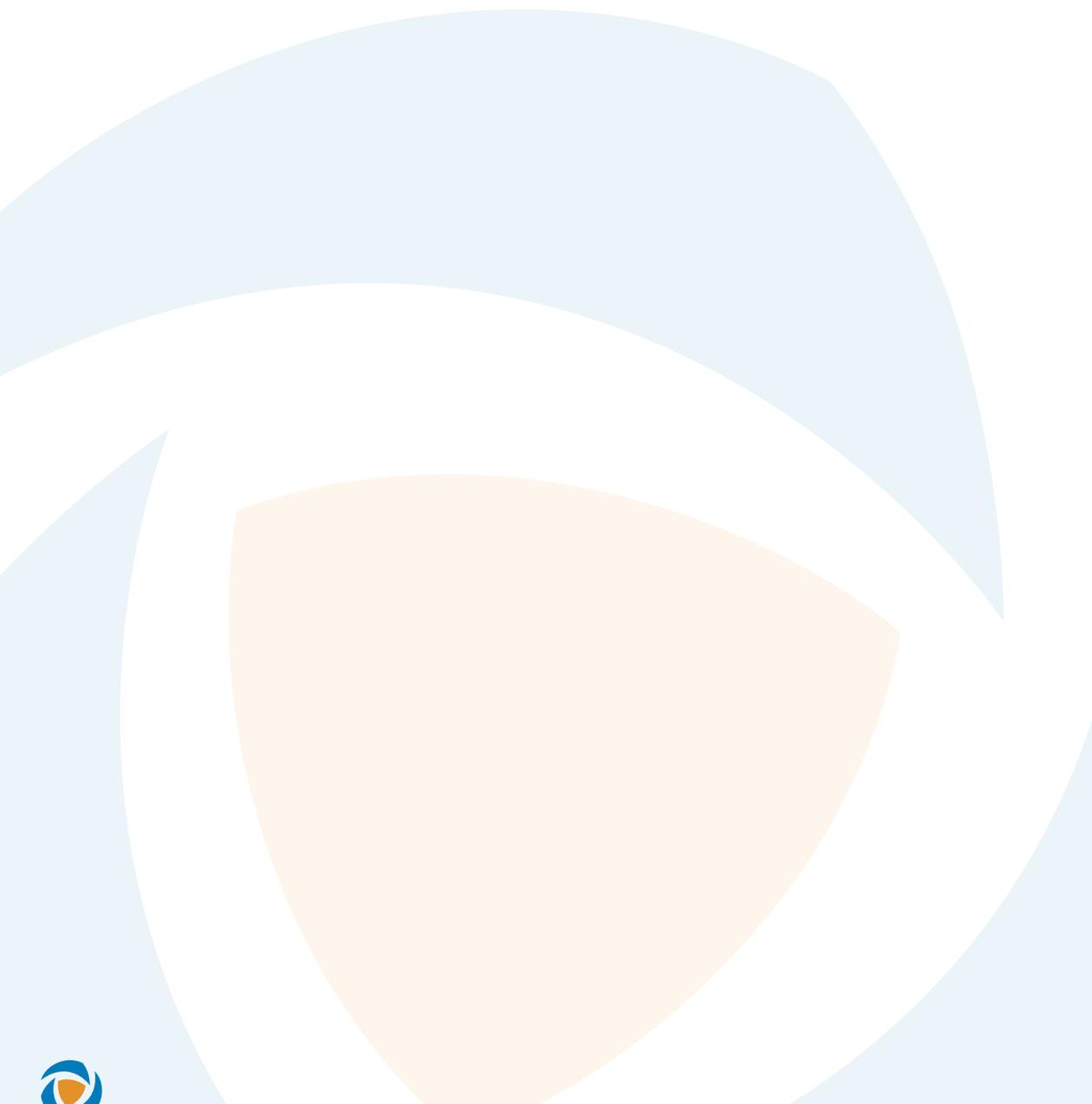
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This booklet comprises key results and summaries from all plenary sessions and workshop during the 3rd European symposium on the Societal Impact of Pain (SIP 2012). The SIP Platform kindly likes to thank all SIP 2012 Proceedings reporters for their contribution. More information is available at www.sip-platform.eu.





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Prof. Hans G. Kress, MD, PhD
President,
European Federation of
IASP Chapters (EFIC)

Dear Reader,

I am pleased to welcome you to the Societal Impact of Pain Symposium, SIP 2012, here in Copenhagen during the Danish presidency of the EU. This third SIP symposium is again kindly funded and logistically supported by the pharmaceutical company Grünenthal and is hosted this year by the Danish Association of Pain Patients (FAKS). I would already now like to thank these two collaborating organisations for their great support.

EFIC is a multidisciplinary professional organisation in the field of pain medicine with 36 National Pain Societies across Europe (IASP Chapters) and representing more than 20,000 scientists, physicians, nurses, physiotherapists, psychologists and other healthcare professionals. We are all actively involved in pain medicine and we all share three major goals: to develop pain medicine, to improve the availability of best practice pain treatment all over Europe and

to attract public attention to pain and chronic pain patients.

As you know, the acronym SIP stands for “Societal Impact of Pain”. Years ago EFIC realised that the public awareness about the tremendous and notoriously underestimated societal impact of chronic pain must be increased, and not only the awareness among health care professionals, but even more so among politicians and among the decision makers in our health care systems. In 2001, EFIC published a Declaration on Pain in the European Parliament. With the support of Grünenthal, EFIC thereafter organised two previous SIP symposia in 2010 and 2011 in Brussels. These past two SIP symposia were important first steps towards the public recognition of chronic pain as a true challenge to patients and their physicians, and to health care systems and societies across Europe.

During the second SIP symposium in 2011, which took place in the European Parliament in Brussels, the “Road Map for Action”, with its 7 strategic goals for improvement of pain care, was launched.

Among the topics of this year's SIP Symposium to be discussed during the next days, workshop 1 will focus on EFIC's position on pain as a disease in its own right. The future position of chronic pain among the disease categories of the International Classification of Diseases (ICD), published by the WHO, will also be in the limelight during this workshop, because a revised version of the ICD (ICD11) is already in the pipeline. It will need a big effort and it is our hope to see chronic pain recognised as a distinct category or even a disease in this revised classification.

Workshop 2 will focus on the influence of pain on active and healthy ageing, based on the EU Commission programme on the European Innovation Partnership on Active and Healthy Ageing. Other workshops will deal with: pain commissioning and best practice cooperation models; education and research programmes; experiences from establishing national and multi-stakeholder platforms; and finally, future trends in policy-making for pain care in the European Union. High-level keynote speakers will pick up these topics in the plenary session following the workshops.

Adequate pain management is not only an ethical duty for all care givers, it should also be considered a basic human right. But without strong political support, high quality pain management and medicine will not reach those who are in most urgent need.

I am sure this SIP symposium 2012 in Copenhagen will be a further step towards the public recognition of chronic pain and towards the acceptance of the tremendous challenge society is facing, and it will also be a further step towards reaching the important goals of the Road Map for Action. These goals are important for our patients first and foremost, but also for the future of pain medicine, for the future development of our European health care systems and of society.

Thank you all for your contributions and welcome again to Copenhagen and this third SIP Symposium.



Prof. Hans G. Kress,
President,
European Federation of IASP Chapters (EFIC)



Alberto Grua
Executive Vice President
Grünenthal
Europe & Australia

Dear Madam, Dear Sir,

Thank you for giving me the opportunity to be here today. We are all at the start of a truly unique event!

To my knowledge it rarely happens that such a large group of high-level representatives from almost all EU member states come together to discuss the Societal Impact of Pain.

Over 400 experts representing different stakeholder groups, such as scientific associations, patient groups, governmental bodies and health care institutions, have come here today to discuss pain management from different angles and contributing their different views and experiences.

In close cooperation with the Danish Association of Pain Patients (FAKS) and the European Federation of IASP Chapters (EFIC®),

Grünenthal is very proud to facilitate the discussion around chronic pain and the impact that it has on our society:

The economic and social burden of chronic severe pain is derived from inherent direct and indirect costs. A burden which our health care systems have to tackle in spite of demographic change and increasing costs for technological advancements.

Due to the high prevalence of pain and its significant impact on patients and society, “pain” should be recognised as a significant health care quality indicator. This is what the “Societal Impact of Pain” is all about. A clear definition of health care indicators measuring pain in the population is important for the implementation of a best practice approach to improve pain care in Europe. I am convinced that this symposium will significantly contribute to move this discussion along.

Various large studies have demonstrated that the prevalence of pain amongst the European population is very high. In fact, pain is the most common reason why patients seek medical attention. Each SIP event has been very special and this year is no different, as more than 160 organisations have confirmed their official endorsement of the scientific aims of SIP 2012. This is an incredible amount of scientific organisations and patient groups, which all support the need for an improved pain management in Europe. It strongly demonstrates the societal impact of pain and illustrates the broad relevance the topic of chronic pain has for such a variety of stakeholders and organisations.

We started this journey together three years ago and once in a while when the topic is relevant it is important to step back to see what has been accomplished. Considering where we were and where we are now, I am proud to say that we have already achieved much. First of all EFIC, the Patient Alliance Europe and Grünenthal have engaged in the discussion and inclusion of chronic pain in healthy ageing and chronic diseases. Secondly, the European Parliament has adopted a resolution on non-communicable diseases, mentioning chronic pain and looking ahead, the Road Map for Action has been designed and is today an instrument to validate and monitor the progress being made.

This year's SIP is also taking place under the high patronage of the Italian Presidency of the Council of Ministers and the Italian Health Ministry: a truly inspiring signal for the aims of SIP and – for me as an Italian – another highlight this year, which I am particularly proud of!

On behalf of Grünenthal, I would like to thank all speakers for their efforts in preparing this year's presentations. I would like to thank you, present here today, for contributing to the discussion with your expertise. I look forward to lively debates on the "Politics" and "Science" surrounding chronic pain.



Alberto Grua,

Executive Vice President

Grünenthal Europe & Australia



Pia Frederiksen
Danish Association
for Chronic Pain Patients (FAKS)
Denmark

Dear All,

I am proud to stand here today and proud that so many of you pain patients, in spite of your pain, have chosen to participate in this conference. I am overwhelmed that so many decision makers and practitioners of different professions, together with us patients, want to use this opportunity to create a platform to put the pain issue on the public, as well as the political, agenda, to help make a difference. I hope that together we will have a couple of exciting and truly inspirational days.

We all know that chronic pain is a very low priority area. Patients can spend years trying to get help, even here in Denmark. I clearly remember the first meeting I went to at Pain Alliance Europe, where I spoke with many of the other union presidents. There was a consensus that Denmark was the perfect place to live because of its excellent health care system. But even here in small, safe Denmark

pain patients are not treated with dignity. That may come as a big surprise. However, I want to stress that if you are suffering from a terminal disease, Denmark is a great place to be. But if you “just” have problems with chronic pain, we are faced with the same problems as the rest of Europe.

I hope the next few days will help to highlight chronic pain as a disease in its own right. It is important that we help develop concrete solutions to improve the poor status of chronic pain. Unfortunately, there is still plenty of room for improvements. We will share good and bad experiences of pain treatment in our own countries. We all know that time is an important issue and untreated pain gets worse over time, so a quick intervention by relevant professionals is essential for a pain patient’s future.

Patients with pain cost society a lot of money. Due to a growing elderly population, the number of pain patients will increase, and we need money to help them all. New pathways of care for patients must be created. Early interventions can save society money and offer the patient a far better quality of life. We must find ways to retain pain patients in work. There must be more education for health professionals, we must learn to live with our pain, and society and our families must learn to live with us. Interdisciplinary measures are a necessity. Patients should receive a holistic approach early in the process and we have to realise that no two pain patients are alike.

I am realistic. I know we cannot change the world during these two days. But every time we are together, every time we once again focus on chronic pain, we will see moves towards change. Here in Denmark, there is now more media coverage about pain than ever before. Our politicians are beginning to realise the impact of as many as 20% of the adult population suffering from chronic pain. It is a massive problem that won't disappear if they close their eyes.

FAKS has been allowed to host the Societal Impact of Pain Symposium here in Copenhagen, and we are very grateful. I wish you all a great time. I know it will be hard, especially for all of you who are suffering from pain yourselves, but as I said, I am proud that you all want to help make a difference. I hope this symposium inspires you to adopt new methods in your own work and secure better conditions for chronic pain patients.



Pia Frederiksen,

Danish Association for Chronic Pain Patients (FAKS)
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WORKSHOP 1

Chronic Diseases: Chronic pain as a disease in its own right



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Chronic Diseases: Chronic pain as a disease in its own right

Reporters: Yvonne Engels, the Netherlands
& James Osborn, UK

Introduction

The objective of workshop 1 was to investigate the position of pain in relation to chronic diseases and identify risk factors for a large number of chronic conditions that have pain as a concomitant disease.

The workshop Chair, Professor Hans G. Kress (EFIC) opened the programme by stating that chronic pain should be considered a disease in its own right. All EFIC chapters support this aim. The co-Chair, Elja Kalso (IASP), hoped that the meeting would contribute to the recognition of chronic pain as a disease, but also as a symptom and an important health threat. The workshop Secretary, Joop van Griensven (PAE), described education as

“Politicians do not know what chronic pain is and fail to understand how cost-effective it would be to put it high on the political agenda.”

the most important aspect to improve the quality of life of patients with chronic pain, while Stefano Coaccioli (School of Medicine, Perugia University), a co-rapporteur, thought that a change of paradigm was necessary regarding chronic pain: “It is a disease of its own and concerns a huge economic burden worldwide”, he told delegates. Sean McDougall (Pain UK) who was also a co-Rapporteur was not sure whether it was helpful to classify chronic pain as a disease in its own right, because

it risked making it the responsibility of clinicians only. He believes politicians do not know what chronic pain is and fail to understand how cost-effective it would be to put it high on the political agenda.

Systematic review on the position of pain in relation to chronic diseases

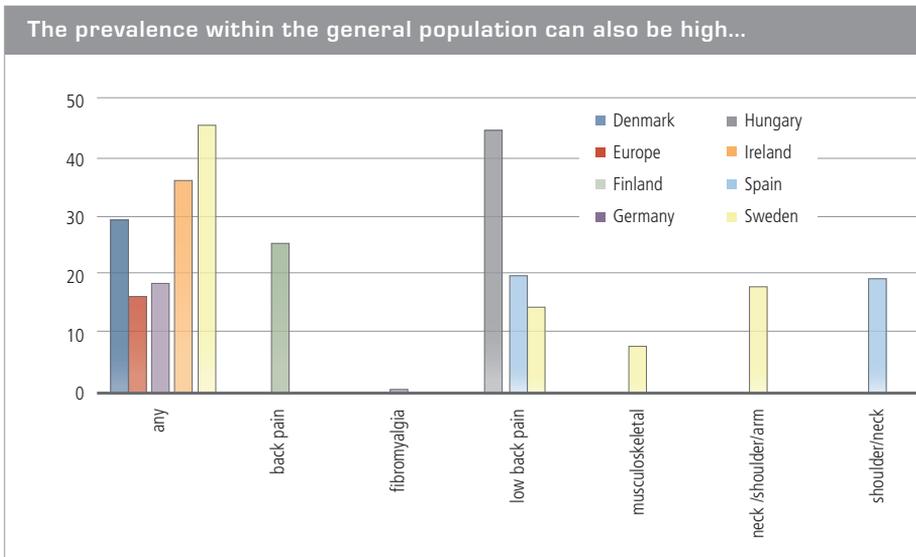
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In 2010, the Council of the European Union initiated a reflection process focusing on chronic diseases. Nigel Armstrong described how Kleijnen Systematic Reviews was invited to analyse the impact of chronic pain in terms of prevalence and cost. Their findings showed chronic pain was common and costly and deserved a higher priority within health policies and budgets.

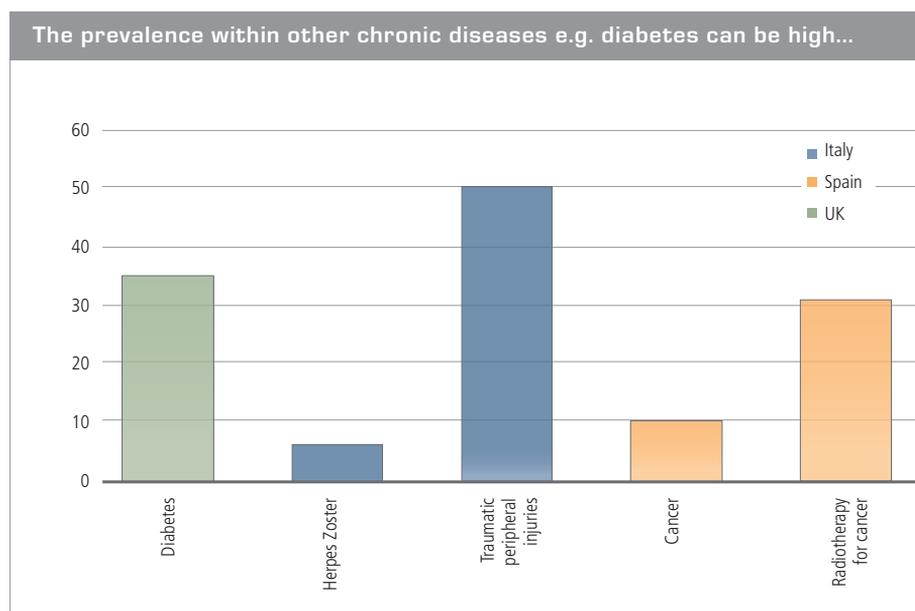
Armstrong continued by putting some of their research findings into context. The prevalence of chronic pain in Europe was between 16% and 46%. Point prevalence was about 17%. This translates to about 80 million Europeans suffering from moderate to severe chronic pain. Armstrong said this was high in comparison to other chronic diseases. Just over 1% of the population suffered from



WORKSHOP 1

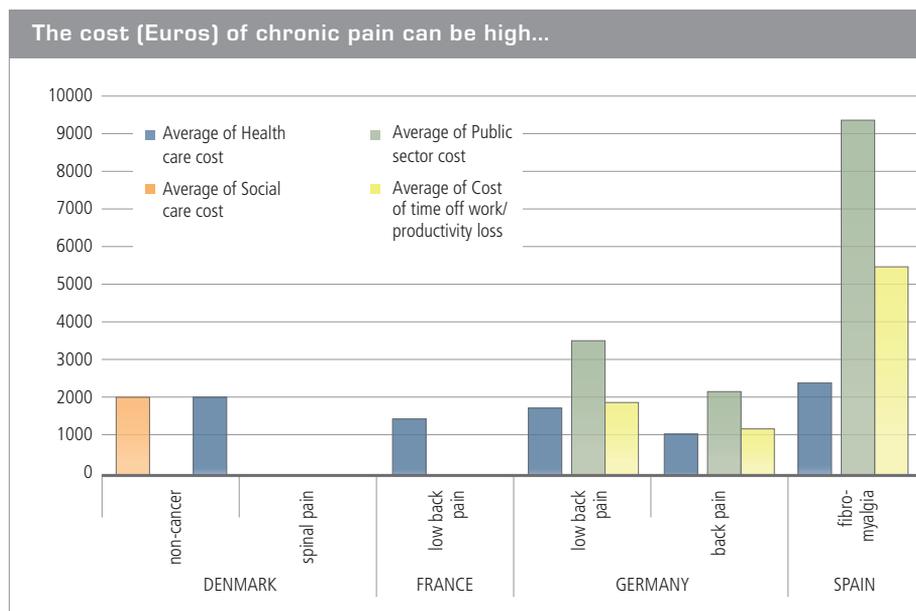
Chronic Diseases: Chronic pain as a disease in its own right

dementia and figures for depression and diabetes were estimated at 4.5% and less than 8%, respectively (EU Major Chronic Diseases Report, 2007). It should also not be forgotten that chronic pain is prevalent in many chronic diseases. Almost 35% of diabetes patients in the UK and one-third of cancer patients in Spain undergoing radiotherapy reportedly suffered from chronic pain as a result of their condition.



The systematic review showed that the cost of chronic pain was also very high, especially due to absenteeism and loss of productivity in the workplace. Armstrong told the workshop audience that, on average, 8 work days had been lost during the past six months. Chronic pain had some sort of impact on the workplace for almost half the pain sufferers. The report also found the cost of healthcare per year per pain patient ranged from about € 1,095 for back pain in Germany to € 3,246 for fibromyalgia in Spain. Social care generally cost a little less and incapacity benefit payments were as high as € 2,267 for fibromyalgia in Spain.

Armstrong concluded on a positive note saying that little by little, chronic pain was becoming more of a priority on national policy agendas. This was especially the case in Italy (Legge 038/2010) and the Netherlands (“Chronische pijn”, published by the Regieraad Kwaliteit van Zorg).





**Dr. med. Detlev Parow,
MBA**

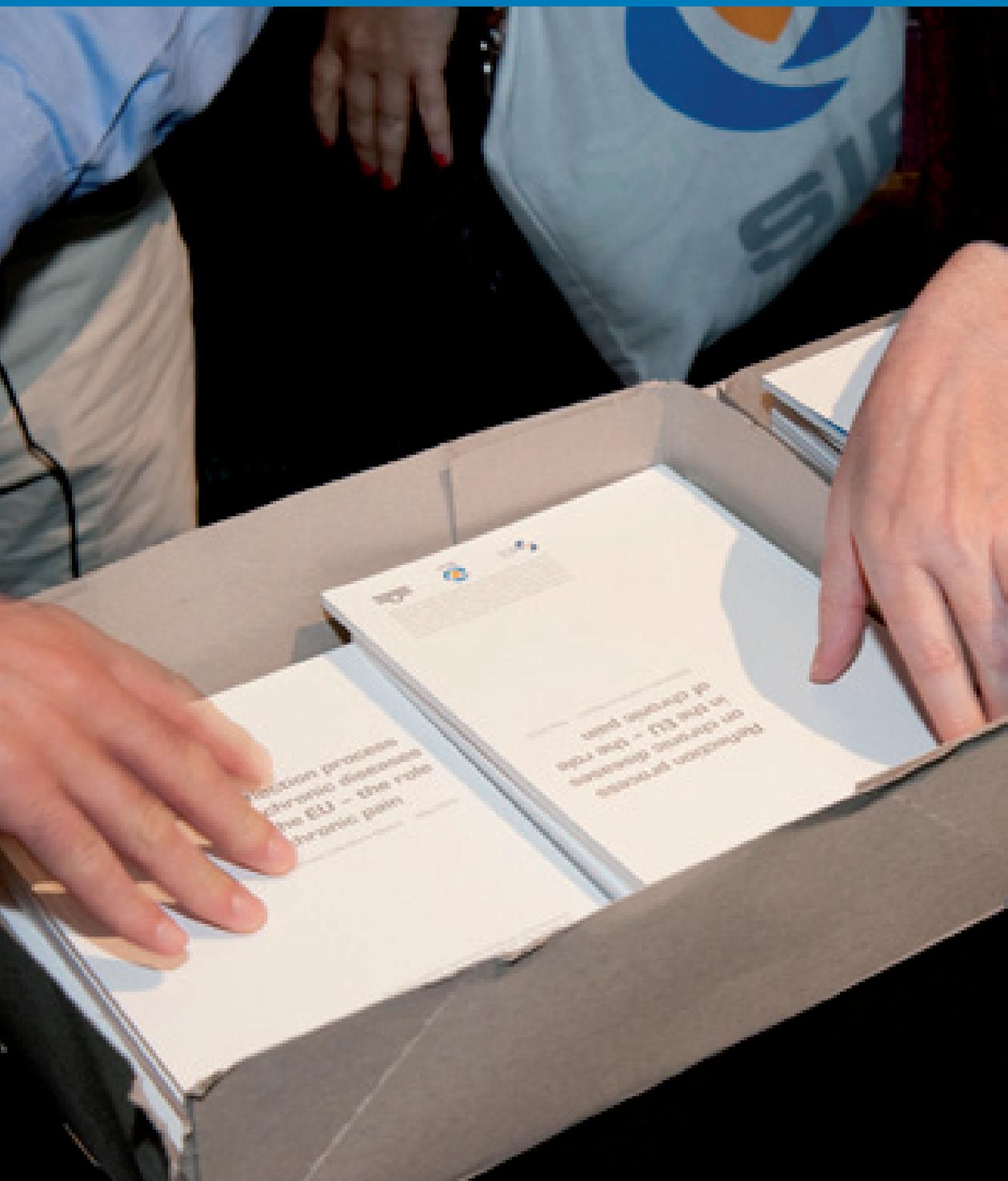
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Pain from a statutory health insurance point of view

Detlev Parow, DAK Health Insurance, Germany

Detlev Parow began by presenting a triangle, which demonstrated the three insurance-related areas relating to healthcare. These were “Customer benefit”, which includes easy access to a specialist and top level treatment; “Quality” with the focus on service provision in line with requirements and “Cost efficiency”, which aims to reduce healthcare provision over time. Parow continued by reminding delegates that the large number of drugs prescribed made pain relevant for insurance companies. He then questioned their actual benefit for the patient, as well asking whether high volumes of prescriptions and drug use made sense.

Parow said the main challenge for insurance companies was providing needs-based care in the face of diverging interests and finding the balance between what producers want and what the insured really need. The triangle referred to at the beginning of the presentation, which revolves around customer benefit, quality and cost efficiency, allowed the insurers to create customised contracts with patients to complement the standard care offered. These new and innovative agreements were multi-dimensional, specific to the target group and customer-oriented. Contract development had to be seen as a continuous learning process with regular performance reviews. Some of the challenges touched on included the varying levels of regional care, insufficient care transparency and a lack of evaluated pain concepts. Using migraine and back pain as two examples, the insurance triangle showed that with migraine there was a high cost outlay at the beginning of treatment, yet there was no change in service consumption over time. Following this experience, Parow stated that unsuccessful contracts should be cancelled, if they could not be adjusted. Back pain results were more promising, as there was more outpatient treatment recorded and the duration of pain was slightly reduced.



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Good practice indicators for pain management in the national health systems. Results of a pilot study

Pedro Saturno, University of Murcia, Spain

In Spain, good practice indicators for pain management (IPM) have been developed and used. Pedro Saturno showed pilot results in Spain's National Health Service, where the objectives of the IPM project had been to build and pilot test a comprehensive set of indicators for pain management throughout the country's health system, based on the best current evidence.

Three different types of indicators were developed for chronic cancer pain, chronic non-cancer pain and acute pain. Following a review of the existing quality indicators for pain management the number of indicators for chronic malignant pain was reduced from 22 to 17 indicators. For chronic non-cancer pain the number was reduced from 46 to 32 indicators. And acute pain was unchanged at 54 indicators.

According to Saturno, some of these indicators were general, others were specific. The revised list of indicators is now expected to be introduced into the public domain. There is still room for improvement once they are up and running. Saturno stressed that medicine was not the only solution to chronic pain. He believes architecture and technology also play a part. For example, buildings needed to be built in such a way that wheelchair users could have easy access to them and their facilities. Technology could develop robots to make life easier for patients with severe chronic pain.



Brian Hammond
BackCare

John Lindsay
Chronic Pain Ireland
Pain Alliance Europe

Rolf-Detlef Treede
Heidelberg University

ICD 11 in development

Robert Jakob, WHO, Switzerland

Robert Jakob began his presentation describing the development process of ICD 11, which is a new version of the international coding system for diseases. It is important for all diseases, entities, symptoms etc, that are relevant, to be included in the development process. ICD has been developed to fit a variety of purposes, e.g. international scientific comparisons and illness comparisons within and between countries. It is meant to code health data about the patient across boundaries.

ICD11 is the first electronic version of the coding system. It will have logical operational rules and will be available in multiple languages. During the development stage, an internet-based permanent platform exists. To make ICD understandable for the general public, all ICD entities will have user-friendly definitions. The final version will be tested and ready in 2014 for public viewing, and from 2015 on it can be implemented. Information about this new development can be found on twitter, facebook, the WHO website and via a video message.

Despite much discussion, the WHO still does not define chronic pain as a disease; rather it is seen as a psychiatric disorder, and "hidden" in other diseases. Before chronic pain can be added to ICD11, there must be a clear and unambiguous definition of chronic pain, which is recognised internationally. Jakob concluded by inviting workshop delegates to influence decisions on this topic by participating in that debate.



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IASP position on pain in ICD11

Winfried Rief, Philipps University Marburg, Germany

Winfried Rief suggested pain should not be regarded as a symptom or a disease, but as a classification. Pain is the major reason for health care use and back pain is the most expensive condition in Western culture. Several major problems regarding chronic pain exist. It is under-diagnosed all over the world. Medical specialists, especially non-pain ones, focus on the disease and not on the pain. The financing of pain management is also unsatisfactory. More pain research is needed. This is why Rief believes a proper classification of pain in the ICD is necessary. Pain can be both a warning and a disease in its own right. In ICD10, pain diagnoses are dispersed over various categories: they are hard to find, and do not have a clear rationale (organ-specific, rest category).

Therefore, suggestions have been made for a new chapter, or section, to be introduced in ICD 11, which would include specific pain conditions e.g. headache, back pain, fibromyalgia and chronic pelvic pain. This move would also reflect latest developments in pain research, classification and treatment. Rief closed his presentation reminding participants that an adequate classification of pain was the basis for satisfactory treatment, integration in health care systems, and continued funding of focused research programmes. He also said the economic consequences of pain could only be tackled once pain had been classified properly.



Prof. Winfried Rief

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Measuring pain as the 5th vital sign

Stephen Gilbert, Chronic Pain Scotland, UK

The American Pain Society (APS) first introduced pain as the fifth vital sign in 1996. Its purpose was to raise awareness that assessing and treating pain was just as important as checking the four vital signs: body temperature, pulse, blood pressure and respiratory rate. Since then, measuring pain as the fifth vital sign has become more widespread, especially across Europe. Stephen Gilbert said the overall objective of this policy was to prevent pain and suffering. It should also help improve the prevention, management and treatment of chronic pain, while assuring pain assessment is performed in a consistent manner and pain treatment is prompt and appropriate and takes an interdisciplinary approach.

Gilbert also explained how pain could be measured in different ways. A number of questionnaires have been developed to assess the extent of suffering e.g. the McGill BPI, the numeric rating scale (NRS), the visual analogue scale (VAS), and the Dolo Test which measures the most relevant domains where pain impacts on quality of life e.g. problems doing your job; reduced energy and strength; problems with light physical tasks and low spirit.

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Trigeminal Neuralgia Association UK



Gina Plunkett
Chronic Pain Ireland

Report from ATOME meeting in Cyprus

Willem Scholten, WHO, Switzerland

ATOME – the Access to Opioid Medicines in Europe project – is run by a consortium of 10 organisations, comprising primarily of policy, medical and academic institutions throughout Europe. The target countries of the project, which will run until 2014, are largely Eastern European although the principle of the project and its outputs can be adopted by other nations.

The core aim of the project is to develop universal policy guidelines; as a first step, multidisciplinary teams analysed each country's situation. The result of this – entitled Ensuring Balances in National Policies on Controlled Substances – is available from the WHO. A recommendation of action report is now being developed, which will be presented at the WHO Regional Committee meeting, Copenhagen, in September 2014.



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EFIC position on pain in relation to chronic diseases

Eli Alon, EFIC, Switzerland

Eli Alon commented that media coverage of “pain” had increased in recent years, with mainstream consumer journals also tackling the issue. He said pain was much more than a symptom. He also stated that EFIC was now getting recognition by the EU as a trusted and influential body in relation to the topic pain.

The term “Chronic, persistent pain is a disease in its own right” was the basis of a declaration constructed by EFIC and signed by a huge number of stakeholders from all across Europe. Alon pointed out that pain not only caused physical immobility. For example, pain in the face could cause huge problems with eating and therefore nutrition. Recent studies using MRI scans to examine the brain revealed physical changes in the brain that correlated with pain severity.

Alon stressed that the burden of chronic pain was huge; not only on the patient but on their family, their colleagues and the economy and society more widely. Chronic pain could also have a profound psychosocial impact on the patient and those close to them. For the patient it could lead to immobility resulting in muscle waste, poor appetite and disturbed sleep.

Alon said treatments were associated with improving certain elements of pain, but effective treatment involved a large multidisciplinary team of health professionals, including anaesthesiologists, oncologists and rheumatologists who had to work together to manage pain for patients and everyone associated with them.



Alberto Grua
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Erhard Hackler
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John Lindsay
Pain Alliance Europe

Why chronic pain is a disease in its own right from a patient's point of view

Liisa Mikkonen, Pain Alliance Europe, Finland

A person that complains "I can't lift this up today, because I'm in pain" is just lazy, according to Liisa Mikkonen who has lived with severe chronic pain for 14 years.

Mikkonen has access to medicine, but not to rehabilitation. Services in Finland are limited mainly due to psychological issues related to pain, because chronic pain is not seen as a disease in its own right. Mikkonen told delegates she had to wait ten years after her accident, which had led to chronic pain, before she received any physical rehabilitation, and even then it was very limited. Getting the official "stamp" from a doctor, confirming that the patient suffered from chronic pain, was the affirmation needed to allow pain sufferers to take a step forward in coming to terms with their condition.

Finally, Mikkonen highlighted the complexity of chronic pain being defined as a disease. "If chronic pain is a disease, what kind of disease is it?" she said, "If there are no other symptoms, it is sometimes considered to be a mental condition – to be treated with antidepressants rather than opioids. This presents a new problem and carries with it another stigma."

„Some governments, healthcare professionals and societies in general are starting to recognise the impact of chronic pain. Many European countries now recognise pain as the fifth vital sign, which should help improve the prevention, management and treatment of chronic pain. However, there is still a lot of work to do. Increasing education around the matter is vital and governments still have to realise that regarding chronic pain as a disease in its own right is actually an opportunity to improve the total wellbeing of citizens. Healthcare professionals should broaden their horizons and consider all aspects of pain, but this issue is not only a medical one: it is the responsibility of every stakeholder, from the authorities to architects”.



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Active and Healthy Ageing: Pain management for an improved quality of life

Presentation: Erhard Hackler, Deutsche Seniorenliga e.V.
German Seniors League, Germany Awareness Campaign:
“Chronic pain and age”

Safeguarding Quality of Life

Chronic pain and age is one of the most important subjects covered by the German Seniors League, which was founded in 1992 as a non-profit, non-governmental organisation. The main focus of the organisation is on age-related health issues, consumer advice and legal aid. The association works across the generations enhancing public awareness and knowledge of issues directly affecting the older generation. The aim is to safeguard the quality of life of today's elderly against the backdrop of demographic change in Germany and in Europe.

A few figures

In Germany, there are some 13 million people with chronic pain and it is estimated that only half of these patients are being treated properly. As many as 40% of patients are dissatisfied with the way they are treated. Many are unhappy as it can take up to six months before they see a specialist. There are not enough pain management centres and just over one-fifth of patients are treated by specialised pain therapists. Certain medicines become discontinued, which can be to the detriment of patients using them. These figures are taken from data the elderly association has collected over the years. It is important to bring this to the attention of politicians in all federal states and nationally. Much still has to be done in Germany to improve the standards of pain care, but also in Europe as a whole.

Pain and age

There are specific issues connected to pain and age. It is well known that the risk of suffering from chronic pain is increased in old age. The elderly are at a higher risk of suffering from pain-intensive diseases, yet many older people have difficulty describing their pain or they might just accept pain as their fate. These facts must be constantly brought to the attention of decision-makers. Family members also have to be informed about the consequences of older people suffering from pain, as it is often the younger family members who look after their elderly parents and many are unaware of certain changes that can occur in old age.

Old people will not necessarily call, when they are suffering from pain. They may say they sleep poorly and are distressed, but they probably will not mention the pain they are feeling. Those who suffer from dementia often find it impossible to express the feeling of pain and

it can become a matter of guessing from their mimics and other indications what it is they are suffering from. This is a situation where pain, as a symptom or a signal of acute pain can, when disregarded, develop into chronic pain. These are circumstances the association is actively trying to help avoid.

Getting the message across

In the past, the League has been responsible for major public health campaigns, some of which related to Alzheimer's disease and bladder weakness. Older people are an important source of information for research projects. Through the association they have contributed to studies on longer working hours and how the workplace can be improved to suit the older generation. The German Seniors League is slightly less member-oriented than its American sister organisation and is focused much more in the public domain. The aim of the German branch is to make sure people are better informed, so that they can make informed decisions. It is important that the older generation is aware of its rights, its entitlements and what demands can be put on government and society. Keeping people informed also means that if they should fall ill and have to visit the doctor, they can approach the health profession as emancipated and knowledgeable patients.

Many of the League's campaigns have been picked up by the media. The Chronic Pain and Age campaign received widespread media coverage, which subsequently triggered a number of requests for further information. The aim of that campaign was to help older people find their way out of the "pain trap" and showed them preventative measures to avoid suffering from chronic pain in the first place.

As well as using the media, information is also distributed through direct mail. Information brochures are the best way to get the message across during a campaign and the information is targeted at both the medical profession and policy makers. 350 to 400 politicians in Germany were sent brochures and we confronted them head-on with our demands, making them aware of the League's objectives and spelling out our demands. The organisation is also highly visible in doctor's practices and we encourage staff to pass on our folders and brochures to patients.

The task ahead

The aim is to target thousands of patients in a much better way in the decades to come, so that patients will see their doctors in a much more informed state. The same message can be brought to the public, but in different variations. Patients should recognise themselves in the campaigns. If they recognise this might be the type of situation they could find themselves in, they are more likely to become active. Twenty years of experience have proven this.

WORKSHOP 2

Active and Healthy Ageing – Pain management for an improved quality of life



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Active and Healthy Ageing – Pain management for an improved quality of life

Reporter: Norman Evans

Introduction

In 2011, the European Council endorsed the European Commission's launch of the European Innovation Partnership on Active and Healthy Ageing. The pilot partnership focuses on three areas: prevention and health promotion, care and cure, and active and independent living of elderly people. The overarching target is to increase the average healthy lifespan by two years by 2020. Workshop 2 addressed the issues related to these outcome criteria, health care indicators and tools to document the quality of pain management and its societal impact in relation to active and healthy ageing.



Pia Frederiksen
FAKS



Pedro J. Saturno
Universidad de Murcia



Alberto Grua
Grünenthal GmbH

Systematic review on healthy ageing in relation to chronic pain in the EU

Jos Kleijnen, Kleijnen Systematic Reviews, UK

With the demographic changes of an ageing population, the European Union and its member states face a tremendous challenge. By 2050 over 30% of the population will be over 65 years of age. The European Innovation Partnership on Active and Health Ageing (EIP on AHA) seeks to tackle these societal changes by fostering innovation and research. One objective is to enable EU citizens to lead an active, healthy and independent life so that the average healthy lifespan increases by two years by 2020.

Chronic pain becomes more prevalent with age, such that over half the population over 75 years suffer. This has many impacts on the quality of life of the individuals, as they may suffer mobility problems and experience a decline in social activities, all of which can lead to depression and anxiety.

Kleijnen Systematic Reviews carried out a European-wide review of the most recent epidemiological data focusing on chronic pain in relation to quality of life in people over 50. The aim of the study was to investigate the correlation of chronic pain, quality of life and ageing and to highlight how chronic pain contributed to the overall health state of Europe's ageing population. Jos Kleijnen pointed out there were limitations to the review, as the average age of study participants was around 40 and no research focused on the over 50s.



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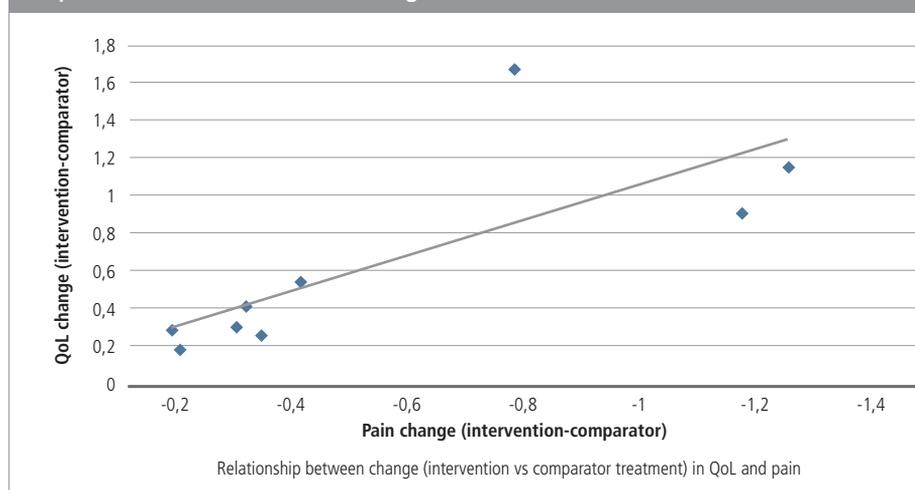
Jos Kleijnen
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Active and Healthy Ageing – Pain management for an improved quality of life

This systematic literature review found a clear correlation between the severity of pain and quality of life. It also showed there was a clear relationship between a change in pain after treatment and a change in quality of life. Pain treatment comes at an enormous cost to the healthcare system, so prevention and treatment should be a priority for policy makers. Prevention and treatment is also likely to improve quality of life and help increase the possibility of a healthy lifespan by two years. Kleijnen stressed that a structured programme to meet these challenges and their long-term consequences was urgently needed at EU and member state level.

Review findings: Clear relationship between change in pain after treatment and change in QoL



Eija Anneli Kalso
President IASP

Joop van Griensven
President Pain Alliance
Europe

Beatriz Craveiro Lopes
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Active and Healthy Ageing – Pain management for an improved quality of life



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The Impact of Pain on Work and Healthy Ageing

Michiel Reneman, UMCG, Centrum voor Revalidatie, Groningen, Netherlands

Chronic non-specific musculoskeletal pain (CMP) is the largest sub-group of patients with pain. It is also the most costly because of work and productivity loss. At least 90% of the general population will suffer at least once in their adult lives. In many cases there is rapid improvement and full recovery. However, up to 78% will relapse and some will develop chronic pain lasting over three months.

The societal costs of CMP are significant. The bulk of direct costs relate to medical care, whilst indirect costs mainly relate to absenteeism, presenteeism, disability and a decreased quality of life. Low back pain is

the 6th most costly health condition in the USA. In the Netherlands the annual estimated cost of CMP is the equivalent of almost 1% of the country's GDP.

Michiel Reneman explained the results of a study among a large and under-reported group of people with CMP, namely those who stay at work (SAW), despite their condition. There was strong evidence that work was generally good for health and wellbeing. The study also showed sustained work participation with CMP was often possible and desirable, but it was important to note that many determinants for SAW with CMP were still unknown. Reneman concluded by telling participants that the results of this study could be used to develop interventions to promote those who stay at work and that those employees should be used as an outcome measure for successful pain management.



Manuela Monleón
Federacion de Asociaciones de Enfermería
Comunitaria y Atención Primaria (FAECAP)



Nigel Armstrong
Kleijnen Systematic Reviews Ltd

Detlev Parow
DAK – Gesundheit

The influence of work-related back pain on sickness absence

Stephen Bevan, The Work Foundation, Lancaster University, UK

Stephen Bevan stated that work was good for people's health and that interventions to support those with chronic conditions should focus on capacity, rather than incapacity. People should be helped to remain economically and socially active through work.

The Fit for Work European Coalition has conducted research in over 30 countries with the conclusion that musculoskeletal disorders account for over 2% of EU GDP with over 40% of men and women reporting back pain in the previous 12 months. Most people with back pain either remain in work or return to work promptly. About 85% of those suffering take less than seven days off, but most of the costs are associated with the remaining 15% who were absent for over one month. Some 80% of healthcare costs are generated by 10% with chronic back pain and disability.

One of the challenges is to prevent short-term absence becoming longer term. Bevan said once a person had been on incapacity benefits for a year, they were more likely to die or retire early, than return to work. Systems needed to be in place in work places across the EU to prevent back pain occurring with early access to occupational health. There is a growing consensus that psychological factors are associated with progression of acute to chronic back pain. Job satisfaction is the best predictor of an early return to work. A holistic approach with good management, flexibility, control over the pace of work and employees being able to contribute to decisions that affect them, are all indicated as helping them return to and stay in work, which allows them to remain productive.



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“Once a person has been on incapacity benefits for a year, they [are] more likely to die or retire early, than return to work”.

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Musculoskeletal pain: incidence, prevalence and impact on healthy ageing

Anthony Woolf, Project Leader EUMUSC.NET,
Royal Cornwall Hospital, UK

Anthony Woolf showed that although musculoskeletal conditions are the commonest cause of severe long-term pain and disability, with increasing prevalence with age affecting social functioning and mental health, there is little priority to their prevention and management in the health care system.

The spectrum of musculoskeletal conditions is broad, ranging from joint conditions to multi-system inflammatory diseases. Musculoskeletal pain often goes undiagnosed and its severity is difficult to quantify, but an important measure is pain, which restricts activities of daily living. It ranks highly in terms of a chronic disease's impact on quality of life.

The Bone and Joint Decade 2010–2020 aims to gain priority for the prevention and control of musculoskeletal conditions. It needs to be recognised that they are a leading cause of disability, as many of these conditions can be prevented. The paradigm needs to change from quantity of life to quantity of quality of life.



Eumusc.net

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EU Commission, DG Sanco

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Skånes University Hospital

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Pain Matters Ltd

The spectrum of musculoskeletal conditions and problems

Musculoskeletal conditions are diverse. For simplicity they may be grouped under:

- Joint conditions—for example, rheumatoid arthritis (RA), osteoarthritis (OA)
- Spinal disorders—for example, low back pain
- Regional and widespread pain disorders
- Bone conditions—for example, osteoporosis and associated fragility fractures
- Musculoskeletal injuries—for example, high-energy limb fractures, tears and sprains often related to occupation or sports
- Genetic, congenital and developmental childhood disorders
- In addition there are multisystem inflammatory diseases which commonly have musculoskeletal manifestations such as connective tissue diseases and vasculitis.



Classification of low back pain

- Non-specific low back pain is when there is no clearly defined pathophysiologic cause. Non-specific low back pain accounts for about 90% of cases.
- Non-specific low back pain is usually classified according to duration and recurrence:
 - Acute back pain is of less than 6 weeks duration;
 - Subacute is between 6 weeks and 3 months duration;
 - Chronic when it lasts more than 3 months.
- Frequent episodes are described as recurrent back pain.

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National Health and Wellness Survey 2010 – 65+ analysis

Chris Wells, President-elect EFIC, UK

Chris Wells opened his presentation posing the question, “Can we achieve healthy ageing?” If the EU objective of an extra two years of healthy life is achieved by 2020, it will be a triple win for Europe. Its citizens will be healthier, more active and independent until old age. Social and health care systems will be more sustainable, dynamic and efficient and the competitiveness and market growth of innovations in the ageing sector will be fostered.

A core therapeutic report in the so-called “Big Five” EU countries with a population of 257.5 million found 52.7 million (20%) had experienced pain in the past month. The mean age of the survey was 50.9 years. Almost

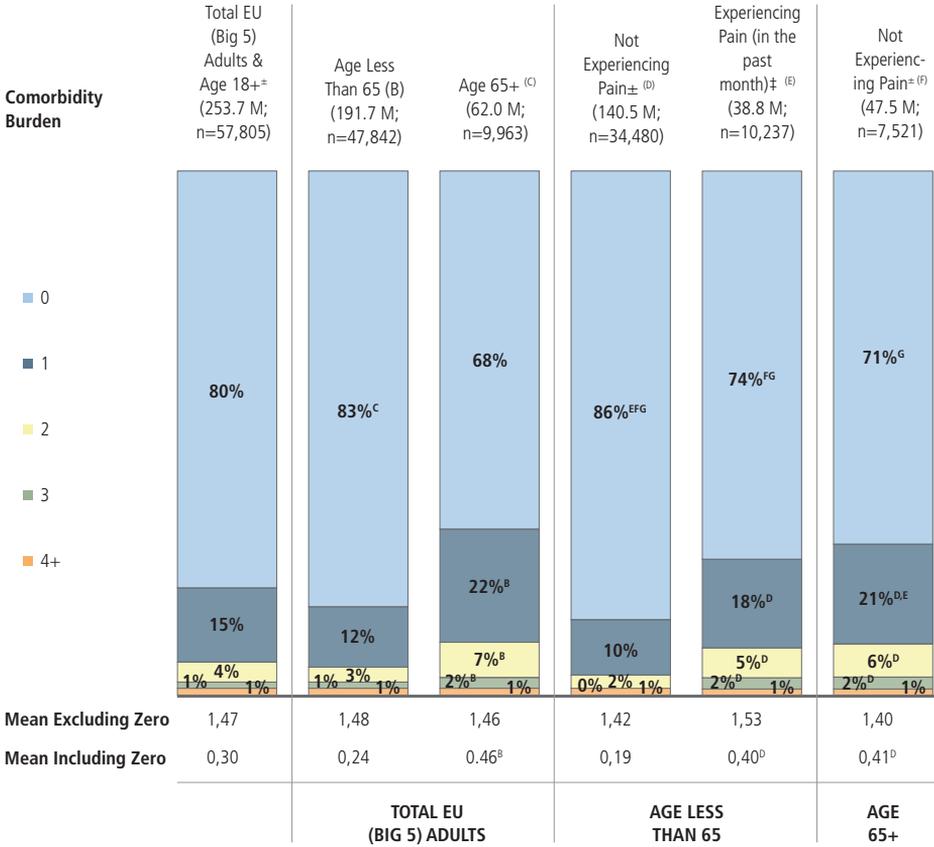
one quarter of those who participated in the study were over 65, which revealed that the incidence and prevalence of pain increased with age and caused a decrease in quality of life. Older patients stayed in treatment for an average of 81 months and took pain medication for at least 6.5 years, which increased the likelihood of serious side effects. An older sufferer was most likely to experience pain daily.

Co-morbidity was also a serious problem, as Wells explained, “Older people not only suffer pain, which is very common,” he told delegates, “but in addition, they might have heart disease, high blood pressure or depression. And these make the pain worse and make it more difficult to treat.”

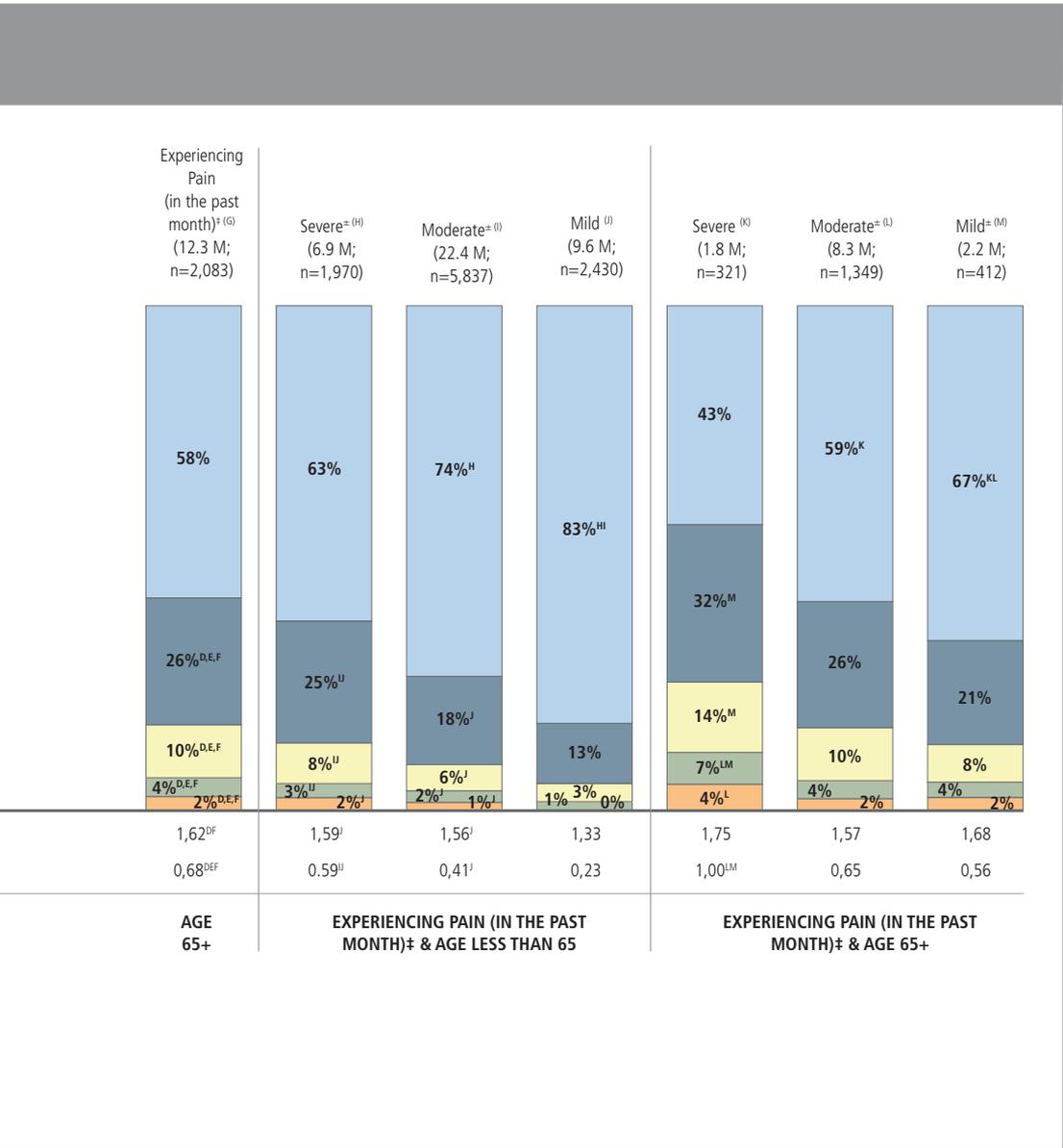
The “Charlson Co-morbidity Index Scores” showed there was a greater risk of co-morbidities with the sample population in more severe sufferers. Patients accessed healthcare resources to a greater extent with physical, mental and general health scores worse than non-sufferers, correlating with age and severity. In answer to his opening question, Wells said that it may be possible to achieve healthy ageing by following the SIP Road Map for Action, which amongst its seven principals, called for timely and adequate access to pain care, the implementation of prevention and education programmes and the monitoring of societal outcomes in pain care.



Charlson Comorbidity index scores are higher in severe sufferers relative to those with mild/moderate pain, in pain sufferers relative to non-sufferers, and among adults 65+ compared to younger than 65.



Zero % implies a very small value less than 0.5%
[‡]Excludes dental problems, headache, menstrual pain or migraine only
[±]Percentages do not add up to 100% due to rounding
 Charlson Comorbidity Index Scoring (please see Appendix for details)
 Letters indicate statistically significant difference @ 95% confidence level between subgroups



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Active and Healthy Ageing – Pain management for an improved quality of life



Orsolya Nagy
Policy Analyst,
European Commission
DG SANCO

Pilot European Innovation Partnership on Active and Healthy Ageing

Orsolya Nagy, DG Sanco, EU Commission, Belgium

Orsolya Nagy stated that EU average spending on healthcare was 9.6% of GDP in 2008 and was expected to increase by 4.75% by 2060. Within this period there would also be a shrinking workforce and insufficient healthcare specialists.

2012 was the European Year for Active Ageing and Solidarity between the generations. To mark this occasion the European Innovation Partnership (EIP) on Active and Healthy Ageing (AHA) was launched as a flagship initiative of the European Commission. The aim is to raise awareness that active ageing can help older employees stay in the workforce, keep playing an active role in society and live as healthy and fulfilling a life as possible.

The target is to increase the number of healthy life years (HLY) by two by 2020. This would provide a triple win for Europe by enabling EU citizens to lead active, healthy and independent lives into old age, improve the sustainability and efficiency of social and healthcare systems and develop and deploy innovative solutions.

Nagy explained that the partnership is in its implementation phase and will be a collaborative innovation with the aim of bringing together stakeholders from the public and private sectors. There will be a three-step engagement: consultation, development and implementation.

Many stakeholders have expressed their intention to be involved in the project and during the workshop Chris Wells, president elect of EFIC, submitted a joint application on behalf of EFIC, PAE and Grünenthal to be a reference site for the partnership.



John Lindsay
Pain Alliance Europe

Orsolya Nagy
EU Commission, DG Sanco

Chris Wells
Pain Matters Ltd

Konrad Labuschagne
Grünenthal GmbH

Pain and Impaired Cognition: Facts and Figures

Wilco Achterberg, Leiden University Medical Centre, Netherlands

Wilco Achterberg began by telling his audience that pain was undertreated in all healthcare settings, but particularly so in dementia. It was a myth, he said, to think that pain was a normal process of ageing or that dementia patients did not feel pain and that the emotional component of pain was reduced. (Facial expressions in dementia)

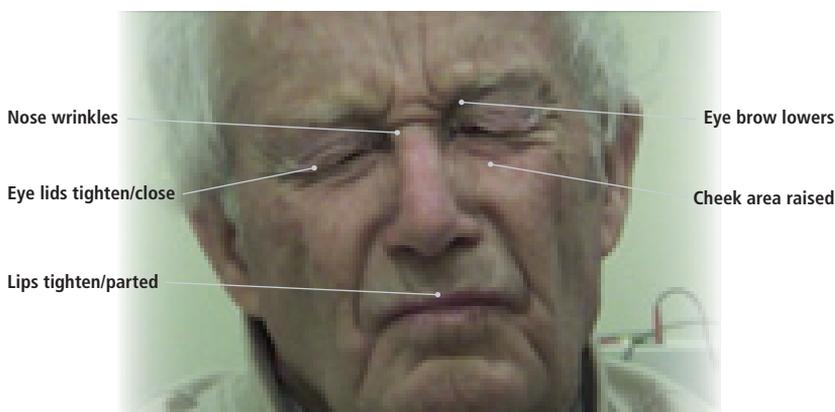
Studies show that pain sensitivity is similar in mild to moderate cognitive impairment, but may be reduced in more advanced dementia. The pain threshold may be unchanged, but pain tolerance may increase. Unrelieved pain increases the problems of dementia. Pain is poorly assessed in dementia. However, the social expressions of pain are not blocked and tools are being developed to assess pain in dementia.

The EU – COST action “Pain Assessment in Patients with Impaired Cognition, especially Dementia” will bring together leading researchers from a wide range of disciplines to develop a comprehensive assessment toolkit. The study is financed until 2015 and within that time five working groups will evaluate and assess the appropriate distribution of strategies for both toolkit and guidelines, as well as analysing and, if possible, correcting scientific, social, and political barriers against dissemination. It is to be hoped that this will lead to an improvement in pain management in dementia.



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Facial expressions of pain



Hadjistavropoulos, 2000, 2002, 2007
Kunz et al. 2007, 2008

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Pain in geriatric care

Sylvie Bonin-Guillaume, French Geriatric Society, Aix Marseille University, France

The burden of pain in elderly patients is under-recognised and undertreated with 75% of patients in care homes reporting pain, but only one third of them being treated. It is believed 20% of elderly patients are unable to verbally express the pain they are suffering from.

“It is believed 20% of elderly patients are unable to verbally express the pain they are suffering from.”

Sylvie Bonin-Guillaume reported on pain assessment tools that have been developed in France. Doloplus uses a behavioural scale for chronic pain, but Bonin-Guillaume claimed it was time-consuming and required training and education. The assessment tool, “Algoplus”, uses five basic behavioural changes, which includes the monitoring of facial expressions and body position. As soon as one of these basic behaviours is observed, a “yes” is noted. No training is required to use this tool. Recently, the French Geriatric Society developed the “Mobiquat” educational programme for the assessment and management of pain in care homes.

In conclusion, a lot has been done to develop tools to improve the quality of pain assessment and management in France and to improve the quality of life, but in the words of Bonin-Guillaume, “There is still a need to develop more pain management processes.”



Winfried Rief
University of Marburg



Maria Teresa Garcia-Baquero
Servicio Madrileño de Salud



Pooja Soens
EFIC Secretariat

Christel Geevels
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Influencing Public policy to drive change in end of life care

Simon Chapman, National Council for Palliative Care (NCPC), UK

The NCPC is a broad based coalition of charities to support changing knowledge, attitudes and behaviour towards death, dying and bereavement. National policy in the UK is to support more people at the end of life to be cared for and to die in their setting of choice. To achieve this it is essential to have access to support services at all times. Most people (70%) want to die in their own homes but the majority (58%) die in hospital.

Simon Chapman stated that dying was our greatest fear, particularly dying in pain, but pain relief must be seen as a basic human right. The National Institute of Health and Clinical Excellence (NICE), which makes recommendations on the appropriate care and treatment of patients within the NHS, has issued quality standards for end of life care. There are also guidelines on opioids in palliative care. In 2011, the NCPC carried out its own research and found many GPs still lacked confidence with opioids and pain relief. The NICE guidelines seek to provide clear advice to ensure a consistent approach to treatment and to improve standards in end of life care.



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Madrid: New Palliative Care Pain Programme

Teresa Garcia-Baquero Merino, Madrid Palliative Care Regional Co-ordinator, Spain

Teresa Garcia-Baquero Merino reported that the Madrid Palliative Care Service was launched in 1990 and that there were now 50 centres across the metropolitan region. The service focuses on the needs of patients of all ages and all diagnoses that may reduce life-expectancy. The goals are to prevent and relieve suffering and enable the best possible quality of life. “Many people don’t know about pain interventions,” Merino told delegates, “and they go from one drug to another without actually using all the tools we have at our disposal in the 21st century.”

The service is offered by a multi-disciplinary team to holistically cover all aspects of pain management on a 24-hour basis with a dedicated telephone number. Over 15,000 people contacted the service last year, two-thirds of the cases related to terminal care.

The care body is currently overseeing and designing an innovative pain clinic, which will provide a comprehensive consultant-led service for the whole region. The aim is to provide a unit providing leadership, teaching and research facilities to explore better and more efficient ways to relieve pain.



Volodymyr Romanenko
Ukrainian Association for the Study of Pain



Alan Moran
Northgate Surgery, Ireland



Virginie van Belleghem
Association Francophone
pour Vaincre les Douleurs
(AFVD)



Erhard Hackler
German Senior
Citizens League

Healthy Ageing: Citizens or Patients?

Teresa Petrangolini, Pain Alliance Europe (PAE), Italy

The Mission of Pain Alliance Europe is to improve the quality of life of people living with chronic pain. Their aims are to have chronic pain recognised

“The Mission of Pain Alliance Europe is to improve the quality of life of people living with chronic pain.”

as a disease in its own right, to create a greater awareness of chronic pain, to promote an EU Policy and to reduce the impact of chronic pain on all areas of EU society.

Teresa Petrangolini outlined work carried out in Italy and the development of the

EU Charter of Patients’ Rights on unnecessary pain. Every individual has the right to know that they do not have to put up with pain. It should be eliminated or minimised. Patients have the right not to suffer needlessly and it must be recognised and respected.

An Italian campaign to highlight pain management in 2012 focused on the right to prevent unnecessary suffering and promote new laws to alleviate pain. A few examples included in the latest campaign were a glossary of useful pain-related words to refer to and a guide to access services and their location. Petrangolini concluded by reminding her audience that “we were not born to suffer”.



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Active and Healthy Ageing – Pain management for an improved quality of life



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Pain and Ageing: a Decalogue

Giovanni Gambassi, Catholic University of the Sacred Heart, Rome, Italy

Giovanni Gambassi began by telling participants that pain is reported in up to 50% of older people living in the community, and in as many as 80% in care homes. He agreed with many delegates that pain should be regarded as the fifth vital sign, which was unfortunately often overlooked in the elderly.

The thrust of Gambassi's presentation was to outline a ten-point scheme for pain. He began by reminding delegates that older patients felt as much pain as the general population and possibly had increased sensitivity to pain. "Pain speaks only one language in all countries", he said, "with perhaps some social and cultural differences." He continued by pointing

out that pain does not come on its own. "Pain is there" he said, "even if not suspected in multi-morbid conditions!"

"Studies have also shown pain is persistent in most cases with people living with chronic pain for seven years on average and with many patients suffering for over 20 years."

Studies have also shown pain is persistent in most cases with people living with chronic pain for seven years on average and with many patients suffering for over 20 years. Many conditions, both physical and mental were associated with pain. "Pain is not a joke," Gambassi stressed. One third of patients reported that pain was so severe they could not tolerate it any more.

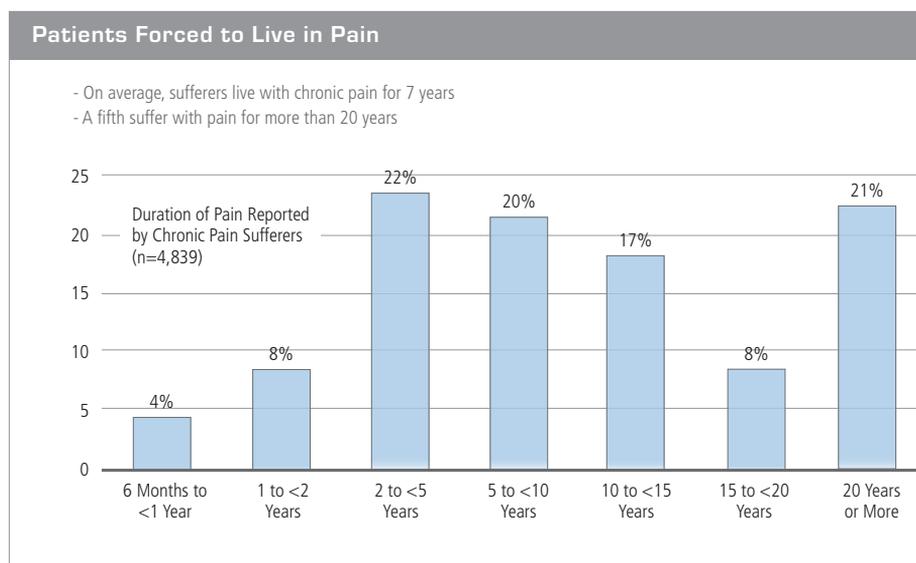
Gambassi also called for pain to be part of a geriatric evaluation and reminded his audience that "Pain is a pain!" He also stated there was often poor training of physicians in the diagnosis and treatment of pain, which could lead to the elderly being less likely to receive adequate analgesia. He wanted to see gaps in pain research filled, particularly in the care of elderly. Looking ahead for older adults, there was still a need to improve pain management and promote the protection of older people's rights and dignity.

Q and A

Answering a question on data for pain in dementia, Wilco Achterberg said the area had been neglected for many years with little or no improvement in access to treatment. However, it had been shown that even late-stage Alzheimer's patients felt pain. Asked about the next stage of EIP on AHA submissions, Orsolya Nagy said that those that met the criteria would be invited to join an action group. Bart Marlion from EFIC asked Steven Bevan

if there were any stimuli to get patients back to work and keep them there. In reply, Bevan reported that there were inadequate links between healthcare professionals, employers and social services. There was a need to encourage work as a beneficial outcome. In the UK, there was a glimmer of hope with benefit payments encouraging the return to work. However, more cooperation was needed, so that people did not drop out of the system.

Further discussion took place on the use of opiates in pain management. It was generally felt that more training was needed in their use but there was also a need to train experts in their misuse, including the legal profession.



„The population of Europe is ageing and its citizens face a tremendous challenge in the future. At least 20 per cent of the population suffer from chronic pain, which increases with age. Many of the contributors to the workshop showed that pain was under-diagnosed and undertreated in the elderly. This was particularly the case in dementia patients.

The general consensus was also that the relief of pain should be seen as a basic human right with chronic pain viewed as a disease in its own right. The pilot EU Innovation Partnership on Active and Healthy Ageing seeks to increase active healthy life by two years by 2020. Finally, there is a strong argument to change perceptions from “quantity of life” to “quantity of quality life” and in the words of Teresa Petrangolini, the representative of Pain Alliance Europe and Active Citizenship Network, “We were not born to suffer”.

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Active and Healthy Ageing – Pain management for an improved quality of life



Improving pain management: Delivering results in best practice cooperation models

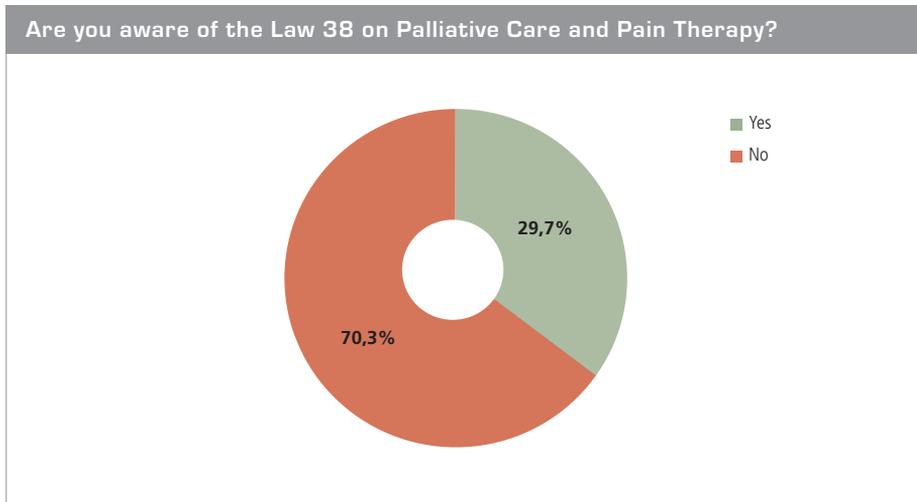
Presentation: Marco Spizzichino, Ministry of Health, Italy
Implementation status of law 38 of March 15th, 2010

In Article 1 of Law 38, which was introduced in Italy in 2010, it states that all Italian citizens have the right to access palliative care and pain therapy. This is a very specific law, because for the first time it establishes two distinct, but integrated networks: the network of palliative care and the network of pain management.

Its aim is to have a very specific path, where key management roles, training and upgrading programmes of the professionals involved are identified. A lot of importance is also placed on information campaigns. A ministerial structure was established

“It is vitally important now to target as much of the population as possible to educate and inform them about their right to appropriate pain care.”

to monitor the two-fold network, and for the first time the law has taken into account paediatric palliative care and pain therapy. Unfortunately, research carried out by the patient association, Cupido, shows that few people know about this excellent law, as yet. Only 30% of citizens know of the existence of this law. It is vitally important now to target as much of the population as possible to educate and inform them about their right to appropriate pain care.



Primary care and pain

Article 6 of Law 38 shows how the project “Hospital without pain” has been turned into a new project called “Hospital territory without pain”. The aim of this new project is to shift the focus of pain care from the hospitals out into the community. GPs and primary health care specialists would be more involved in a patient’s pain management programme and hospitals would only be relied on for complex pain cases. For this reason, an army of doctors have been specifically trained to deal with pain. This project to train doctors in pain management is on-going.

Law 38 was not a complete package and legislators have left some details to be specified by pain specialists. This has to be dealt with at a regional level, because as Italy is a federal state with the regions and local authorities playing a strong role in decision-making, health care matters and proposals have to be shared. It was therefore necessary to identify, as a high priority, whether or not all the regions and their hospitals had the capability to manage these two integrated networks. If it is not known what happens on the ground, the networks cannot possibly function.

Another very important aspect has been to define the professional figures that should be included in this two-prong programme and draw up the first reference list of pain specialists. Training is paramount. The Italian Ministry of Health and the Ministry of Education and Scientific Research have established five new post-graduate degree courses for general medicine, psychology, palliative care, paediatrics and physiotherapy.

Basic minimum requirements

An important part of this law, which can be found in Article 5, Paragraph 3, is to create the basic minimum requirements and organisational conditions necessary to accredit pain and palliative care facilities. This is to ensure patients receive the same level of service, whether they live in the north of Italy or the south. For this to succeed, the pain therapy structure has to be clearly defined, because these centres need to have very specific staff, specific equipment and also be easily accessible for patients. The issue of financing has been a major component of discussions between the state and the regions and with both groups now in agreement regarding money a working tool should be available in the near future to help measure accreditation requirements.

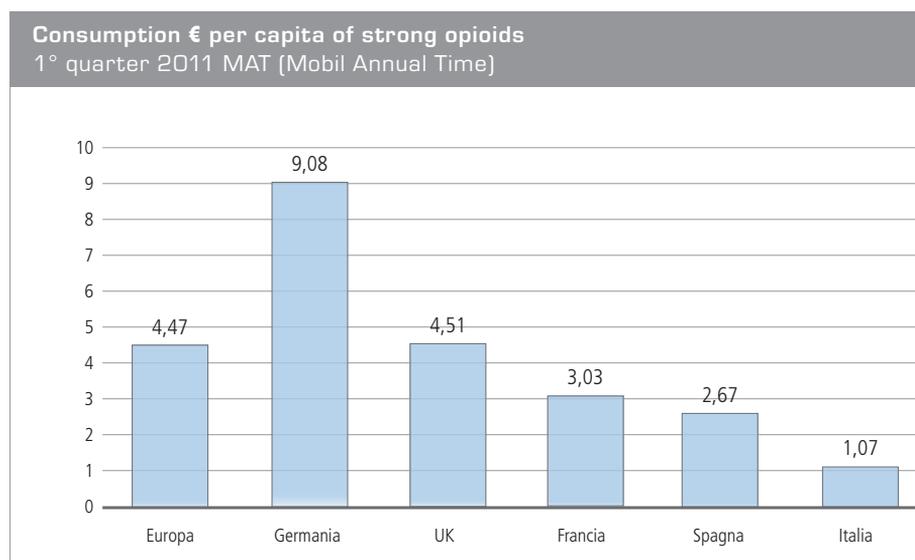
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Active and Healthy Ageing – Pain management for an improved quality of life

Final document

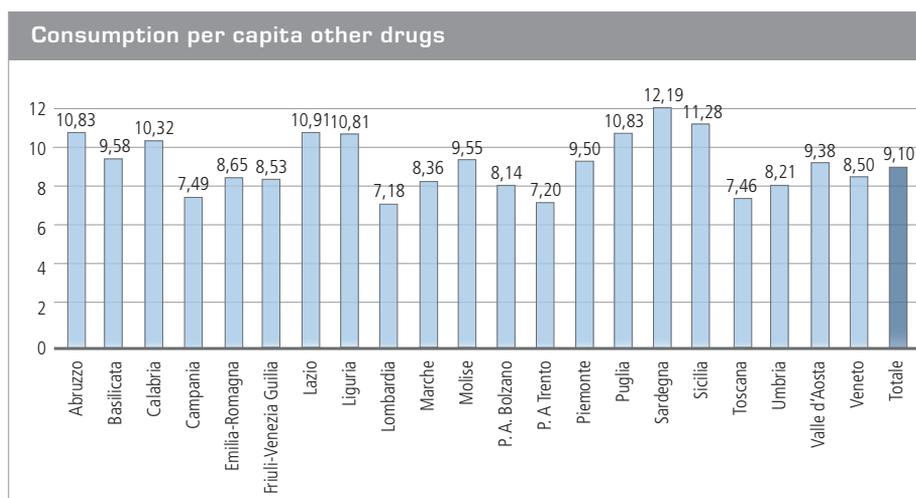
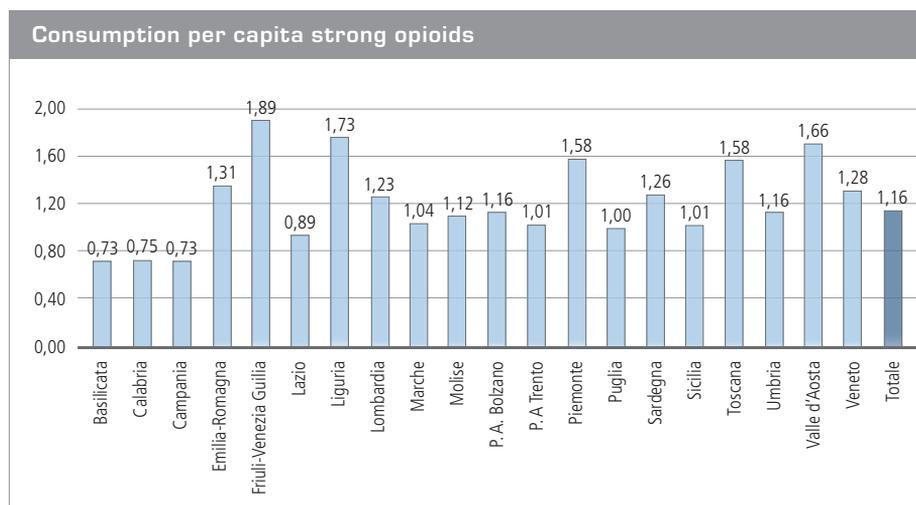
The final document is the result of work carried out by specialists in palliative adult care, adult pain therapy and paediatric palliative care and pain therapy. To determine the existence of a network, a list of 110 specific points was drawn up. The aim is for Italy to be homogenous when it comes to pain care. Obviously, a paramount aspect is monitoring the implementation of the law, so very specific tools have been designed to monitor data on the prescribing and use of drugs in the treatment of pain, and in particular of the opiate analgesic drugs, both at home and in hospitals. The data can be found in a patient's medical history.

A very important element is Article 10 of Law 38/2010, because this simplifies the procedure for prescribing drugs to be used in pain therapy. European figures taken from the first quarter of 2011 (IMS MIDAS Marzo 2011), showing the consumption per capita of strong opioids, revealed Italy consumed substantially lower amounts than Spain, France, Germany and the UK. It also showed Italy's use of strong opioids four times lower than the European average. However, for Italian standards this was a 23% increase on the previous year. The



reason for this could be due to cultural differences or a lack of training of doctors in the use of opioids. Local regional studies show there may be cultural aspects to the differences in opioid consumption, because in the north of Europe, as in the north of Italy, the use of this drug is much higher compared to southern regions. The picture is more homogenous for other types of pain killers. A European network for pain management is in the pipeline to exchange information and make comparisons.

A small sum of money has also been set aside for communication and marketing purposes. The largest project to date to benefit from this money has been “Agenas”, a community project set up by the Ministry of Health. Young people below the age of 30 were asked to help create a slogan, a logo and a poster for a screenplay, which would be developed into a TV advert. The successful poster showed the word pain written in a number of languages with a blue sky revealed behind what looked like a tear in the poster, signifying a symbol of hope. The winning slogan, “I can’t stand you any more, pain must not be supported, but eliminated” is a sentiment felt by anyone who has experienced pain.



Presentation: Gerhard H H Mueller-Schwefe, Germany

Can integrated pain care save money?

Prevalence and impact of back pain

Back pain is a serious problem in Germany. 1.8 million inhabitants, out of a total population of 80 million, suffer daily from back pain. It is the most common problem for pain-related conditions in primary care with every third patient suffering. It is even more prevalent in general orthopaedics.

According to a German study (Hildebrandt J and Mense S, Der Schmerz 6: 411-412, 2001), worldwide back pain is the main reason for medical treatment and the lifetime prevalence is 85%, which means almost everyone has back pain at some point in their lives. Point prevalence is 40%, which means at any one time two-fifths of the population is suffering from back pain. The research also shows, 10% of these patients develop chronic pain and 5% of patients are responsible for 50% of the total cost of pain care. It is estimated the annual loss to society is the equivalent of 600,000 working

years. More than 48 billion euros are spent every year in Germany for back pain and more than 70% of that is for sick leave and early retirement.

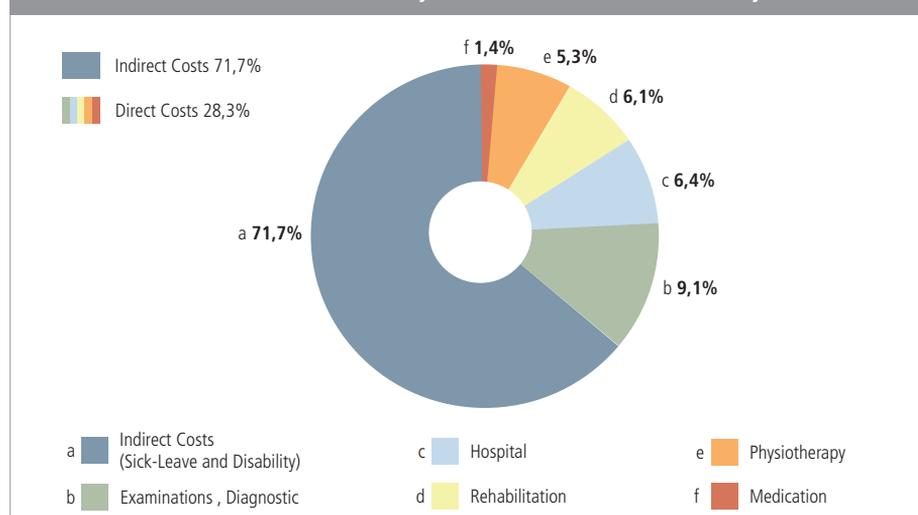
A health report carried out by the Techniker Krankenkasse (TK) showed 10% of their clients were unable to work due to back pain. More than half of those suffered from lower back pain (TK-Gesundheitsreport 2009).



Deutsche Gesellschaft für Schmerztherapie e.V. (The German Pain Association, DGS)

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Total Cost of Back Pain in Germany: 48 500 000 000 € annually



Compared to other countries like the US, Sweden, the Netherlands, Israel and Denmark, Germany has the highest rate of early retirement (Hildebrandt J and Mense S, 2005). The international comparison also showed there was only a 35% chance of a patient returning to work if she had been off work for more than three months. This means the longer a person is absent from work the less likely she is to carry out a normal working day in future. This shows it is not the MRI scan or the medication that counts, but the timeline. If there is no early intervention, the situation will continue to get worse.

Investing in the minority

Treating back pain in Germany can be a slow process, which includes visits to the GP, a prescription for OTC (over-the-counter) medication and possibly an X-ray or MRI scan. During this period a lot of time has passed, often without a positive result. Thus it could be assumed that the German healthcare system creates with highest financial efforts the poorest results. There should be a different process. Patients at a high risk should be identified as soon as possible and preventative measures introduced to protect them from becoming chronic pain sufferers. There would be a high cost outlay initially, but this would only be for a very small percentage of all those suffering from back pain. 90% of all back pain patients return to work within 6 weeks. The group of patients that should be invested in makes up only 2% of the 10% who suffer more than 6 weeks. Those patients with ongoing pain cost the most and it is they who should receive integrated pain care.

“Those patients with ongoing pain cost the most and it is they who should receive integrated pain care.”

Integrated pain care

Taking this small group of patients into account an integrated pain care programme has been set up, which promises less pain, a better quality of life with higher patient autonomy and self-competence and less hospitalisation and less surgery. There should be early intervention against the condition becoming chronic and time is crucial. In fact, access based on timelines is more important than diagnosis or any other finding. Another of the key issues is reduction of sick leave costs.

The whole programme is set up as a network of primary care practitioners working in multidisciplinary centres of excellence. There is an interdisciplinary diagnostic screening prior to inclusion on the programme, which is designed specifically for each individual patient and includes treatment from a pain specialist, a psychologist, and a physiotherapist. And new for Germany, it is not the GP, nor the healthcare specialist who assigns the patient to the treatment programme, but the health insurance company, because they are the only people with a patient's data on sick leave. Using this data, insurance companies can approach patients and ask them if they want to join the programme. The goal is to

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Active and Healthy Ageing – Pain management for an improved quality of life

prevent the condition becoming chronic. Patients undergo a diagnostic screening by the multi-professional team and if the patient is committed to the programme, they go onto Level 3, which is comprehensive outpatient treatment. There is also a model for a second opinion. This also goes via the same screening team.

Inclusion/ exclusion criteria

Only patients who have been absent from work for a minimum of four weeks due to their pain can be included. This is because in Germany insurance companies start paying out after six weeks. Up until that point it is the employer who covers health cost issues. Patients can also be included if there has been no sufficient pain control in standard care, if the individual is motivated to participate and if no end of sick leave is foreseeable. Those with a malignant tumour or inflammatory rheumatic disease are excluded from the programme, as are those who lack motivation. This is a key issue.

The need to be motivated

The screening procedure has to take place within five days after the patient has been offered the programme and includes one hour each with a psychologist, a pain specialist and a physiotherapist. If considered suitable, the patient begins a four week multi-modal treatment, which requires a series of one-hour visits to the three specialists three times a week. Most patients have four or five hours of treatment three times a week. This cannot be achieved if a patient is not motivated or not ready to take on this responsibility.

The goal is to have a patient back in the workplace after four weeks. An additional four weeks can be added to the programme. The outcome should be a sustained ability to work. If the pain continues, there is a re-evaluation after six months. If the patient is successful and is able to work after four weeks of treatment and stays at work for another six months, with not a single day of sick leave, the multi-modal team receives a 500 Euros bonus. If the patient does not return to work after eight weeks there is a malus – a minus of 250 Euros.

The importance of keeping a record

Ongoing team conferences discussing what progress is being made and whether a treatment should be changed ensure the patient gets what is needed. All health professionals involved use the same documents to update their patient's progress and the treatment is regulated according to what the patient reports, not by what physicians believe patients have wrong with them. The documents used are the standardised German pain questionnaire, which is filled out every month for three months, and the pain diary, which should describe pain intensity during any one day. There is a re-evaluation after six months, followed by an external Quality Assessment (QA). Relevant is what patients report. The information is immediately scanned into the computer and is available to all working units. The team is able to monitor on a daily basis maximum and minimum pain intensity, anxiety and even the onset of depression.

Integrated pain care outcomes

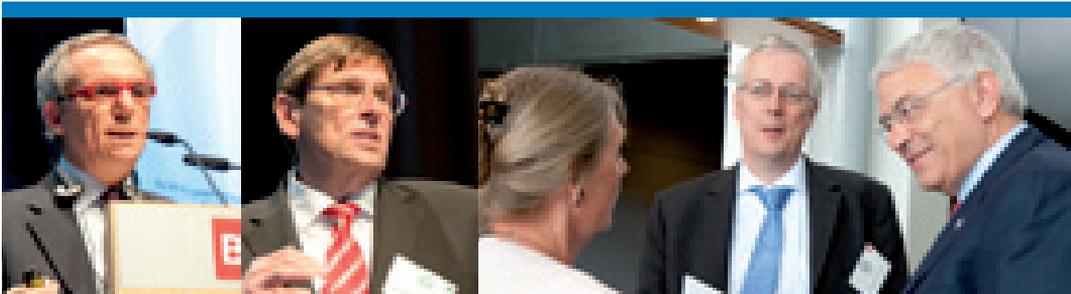
There is a benchmark in each of the 41 centres in Germany to show the effectiveness of this back-to-work programme after four weeks and eight weeks, as well as monitoring the number of screening failures. Out of almost 6000 patients who had been invited to participate, 24% were considered “screening failures”. This was due to participants having additional diseases, e.g. cancerous tumours, or they were not motivated.

86% returned to work after 4 to 8 weeks of treatment. It should be noted that after three weeks of working disability in a standard care programme only 35% return to work. According to a study carried out by TK, this means there is a 52% reduction in working disability. So, if the Average Working Disability control is 172 days of sick leave, it now becomes reduced to 86 days. After 6 months there was a further improvement of Quality of Life (QL), because the group of patients had learned techniques to prevent the same debilitating pain occurring again.

Can Integrated Pain Care save money?

The Average Working Disability cost is 55 Euros. This is the amount paid by the insurance company for sick leave. If the average number of sick leave days is 172 days multiplied by 55 Euros, the total comes to 9,460 Euros. A fifty per cent reduction would bring that total to 4,730 Euros. Expenses for the care treatment cost 3,700 Euros. This suggests that integrated care for back pain patients could result in an estimated, 1,000 Euros saving per patient. It also means those centres with a higher rate of workplace returnees save more money than those with fewer returnees. The insurance companies gain with every patient referred to this programme. So money can be saved, but habits have to change. Timelines are crucial. Early intervention should replace lengthy diagnosis periods. The right patients should be identified early on and there have to be multidisciplinary screenings. This can only be achieved with a team effort and most importantly, we should rely on patient reported outcomes.

“This suggests that integrated care for back pain patients could result in an estimated, 1,000 Euros saving per patient.”



Marco Spizzichino
Italian Ministry of Health

Gerhard H.H.
Müller-Schwefe
German Pain Association

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Danish Member
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Improving pain management – delivering results in best practice cooperation models



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Improving pain management – delivering results in best practice cooperation models

Reporter: Andrew Littlejohn, UK

Introduction

Chronic pain seldom shows up in international surveys. Many in the medical profession believe this is due to the lack of accepted indicators in pain management. However, there is evidence that pain treatment programmes (both acute and chronic) can reduce suffering for the patient, improve outcomes for practitioners, reduce costs and keep people in work. Proving the benefits of these pain programmes can lead to the ring-fencing of budgets and resources in pain management. Spain, Sweden, Portugal and the UK are just a few of the numerous EU member states where very promising commissioning and cooperation models have been initiated. In this workshop, health care providers and commissioners discussed, alongside consumer and patient representatives, models of best practice and measurable deliverables in pain management, which also included strategies to move forward.



Second opinion in back pain

Gerhard H Mueller-Schwefe, Deutsche Gesellschaft für Schmerztherapie e.V., Germany

Gerhard Mueller-Schwefe spoke about Integrated Pain Management, which is a model where back pain patients, who are considered one of the most expensive groups of patients in our healthcare system, are integrated at a very early stage into a multi-modal pain programme.

According to Mueller-Schwefe, pain management in Germany is still a fringe area of medicine, despite 1.8 million Germans suffering from back pain on a daily basis at an annual cost of 48 billion Euros. More than 70% of this amount is paid out for sick leave and early retirement. Mueller-Schwefe told delegates that the financial impact on society was huge: "We don't count the zeros anymore" he said, "but this is the equivalent amount the German government paid for saving banks in the country after the collapse of Lehmann Brothers."

In the past, back pain surgery has been very lucrative financially in Germany, but according to Mueller-Schwefe, "often with poor outcomes and little pain relief". With this in mind, the focus turned to second opinion screenings. This integrated pain management model was designed for patients already scheduled for spinal surgery. Patients refer themselves or are referred by a physician and the screening process is complete within 48 hours. The screening team comprises of a pain specialist, a physiotherapist and a psychologist and it is mandatory a patient spends one hour with each specialist within those two days. Mandatory instruments used to look at preliminary findings are the German Pain Questionnaire, the Fear Avoidance Beliefs Questionnaire and the Functional Impairment by Back Pain Questionnaire.

"The financial impact of pain on society is huge: "We don't count the zeros anymore, but this is the equivalent amount the German government paid for saving banks in the country after the collapse of Lehmann Brothers.""



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Of the 600 patients who have been screened in Germany's 30 medical centres only 14% have undergone surgery, another 14% were put in a special multi-modal care programme and 72% received a standard care programme. In total, 86% of the screened patients did not require surgery in the end. And this picture stayed the same twelve months later.

On average, spinal surgery costs 5,000 Euros, the screening procedure is 300 Euros. The total cost of the second opinion programme is 151,000 Euros. The average cost of spinal operations per 100 patients has been estimated at 500,000 Euros. This means there has been a saving of 350,000 Euros per 100 patients. Put that alongside the 600 patients who have already been screened for a second opinion and there is a saving of more than 2 million Euros. If this figure were to be calculated for the 230,000 patients who undergo spinal surgery in Germany potential savings could be as much as 800 billion Euros.



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Commissioning Pain Management Services

Frances Cole, NHS Kirklees, Bradford Teaching Hospitals Trust, West Yorkshire, UK

Frances Cole focused on the commissioning of pain management services and specifically what patients could do to manage their own health. She began by asking what care pathways were needed for people suffering from long-term pain.

Cole is part of team delivering a multi-dimensional pain programme at NHS Kirklees in Bradford, which serves a population of half a million. The aim of her workshop presentation was to highlight the experience of working with long-term pain sufferers in terms of commissioning. “You suddenly realise

if you are working with a team from the commissioning side you need to be working in a very collaborative way,” she told delegates, “and you need some idea of where you are going, so you need a map.”

The first priority after coming together as a team was to create a map that would make sense to everybody. The “Rainbow Model of Health” was considered, which public health practitioners use to look at the needs and issues of those people who have a whole series of health care issues in a population. The group needed to know more about the impact of long-term pain on health as a resource for living, so they started to populate the map for the population of Kirklees in West Yorkshire.

Cole went on to talk about the use of the stepped care levels of provision or the healthcare pyramid when talking about commissioning, where the largest section at the bottom of the pyramid represents the large percentage of self-care patients. The small percentage at the top of the pyramid represents patients with complex pain issues and a high number of co-morbidities. Another framework to help shape thinking in terms of assessing and planning was the NHS Commissioning Cycle, which has patient and public engagement at the heart of it.

On a local level at NHS Kirklees there were some national policies to refer to from the Department of Work and Pensions (DWP), NICE and the Royal College of General Practice. The aim was to shape a patient-centred pathway that made people healthy by managing their own pain. To achieve this, patients needed better information about self-care, they needed to have confidence in their GP and see the right clinicians at the right time. And the continuity of care should be seamless. Clinicians needed more training, to allow more time for patient consultations and to be aware of self-help resources. Part of the problem is that people are waiting too long to get to the right places that can help them with their pain management. "Often the focus will be on trying a range of pain relief medication over weeks and often months before a patient is referred on to other specialist services", Cole said. Physical functioning was the top priority for patients and waiting lists for physiotherapy with more specific skills were often too long. Cole stated that timely access to the right services was essential to prevent distress and disability. The key focus has been to shift away from how a service operates to what it achieves. Person centred outcomes puts people at the centre of commissioning and makes sure health practitioners concentrate on what difference they want to make.

After four years there has been better use of self-care services with 90% less referrals to a pain specialist and 50% fewer patients using primary care services. More GPs are confident in prescribing drugs and using self-care resources and costs are coming down.

"After four years there has been better use of self-care services with 90% less referrals to a pain specialist and 50% fewer patients using primary care services. More GPs are confident in prescribing drugs and using self-care resources and costs are coming down."



Joop van Griensven
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Defined outcomes from the implementation of pain management in a National Healthcare System

Beatriz Craveiro Lopes, EFIC, Portugal

Beatriz Craveiro Lopes reported that one in seven of Portugal's ten million citizens suffered from moderate to severe chronic pain. A study on the Prevalence of Chronic Pain in the Portuguese Population (Castro Lopes, 2008) showed a large difference between gender and age groups. Prevalence was much higher in the female population and in older age groups. More than 35% of women had experienced chronic pain over the

age of 55, whereas for the same age group only 10% of men claimed to suffer. The same study showed that more than two-fifths of patients were being treated.

Portugal is one of the few European countries that has already implemented pain management in its National Healthcare System. It started in the mid-1990s, when the Portuguese Association for the Study of Pain (Portuguese Chapter) convened a meeting at which the societies of anaesthesiology, neurology, neurosurgery, physiotherapy,

"In 2003 pain was recognised as the fifth vital sign."

orthopaedics, oncology and rheumatology considered pain as a disease. Another main milestone came in 1999 with the Annual National Day Against Pain. In 2001, the National Plan Against Pain was established and two years later in 2003 pain was recognised as the fifth vital sign.

Other general objectives have been achieved or are on-going, such as educational programmes, guidelines for pain management in the elderly and guidelines for pain management in children.

Figures from the Health Ministry show that in 2011 almost 3.5 million DDDs (Defined Daily Dosage, as recommended by the WHO) of weak opioids were prescribed to patients and 1 million strong opioids. The retail market expenditure for the use of opioids in 2011 was more than 8 million.

A study looking at indirect costs of chronic pain in the lower back and joints (M. Gouveia, 2011) showed women were absent from work for 14 days in the year, men for 6 days per year. Absenteeism due to back pain cost the economy 740 million € in 2011, which represented 0.5% GDP. This shows that the difference between direct and indirect costs is enormous.

To keep costs down, there is now an urgent need to invest in, develop and strengthen efficient prevention and treatment strategies to mitigate the consequences of chronic pain and suffering of the Portuguese population. Craveiro Lopes concluded by reminding delegates that currently “it is more expensive to treat pain than to prevent it.”

“It is more expensive to treat pain than to prevent it.”



WORKSHOP 3

Improving pain management – delivering results in best practice cooperation models



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Precariousness and pain. The added value of expert patients

Martine Chauvin, AFVD, France

**Virginie van Belleghem,
Pain Alliance Europe**

Martine Chauvin founded the Association Francophone pour Vaincre les Douleurs (AFVD) in 2006. The non-profit patient organisation represents chronic pain patients and their carer in France. Chauvin began her presentation reminding delegates of the multiple and multidimensional consequences chronic pain can

have on patients. 21% of European chronic pain patients are completely unable to work. 19% lost their job due to their condition.

The complexity of the situation and the various consequences of chronic pain regularly put patients in precarious situations, especially financially. Chauvin explained that separation and divorce was a known consequence for chronic pain sufferers and could be a financial burden if it came to finding new accommodation. The loss of one's job resulted in the loss of income, which again put people in difficult financial situations. And the loss of support due to lack of understanding from family, friends and colleagues could lead to isolation and loneliness.

Chauvin believes little is truly understood about the complexity of the situation, "pain patients' precariousness is underestimated," she told delegates, "and this is worsened by the absence of recognition of chronic pain as a disease."

Chauvin went on to describe the impact poor chronic pain management can have on patients. 50% of pain sufferers have to wait more than a month before being able to access a pain consultant, which results in dedicated pain care being delayed. Medical training in pain has been on the health curriculum for more than ten years, but Chauvin believes these pain programmes could be further developed and their status within the medical profession improved, as pain management programmes are inadequate and incomplete. And there is not enough financial support for research.

The final section of Chauvin's presentation focused on the "expert patients" who are experienced chronic pain sufferers "at peace" with their situation and who have become key players in recovery programmes. "They motivate other patients", said Chauvin "They also complement and actively participate in the patient management process coordinated by health professionals." After dedicated training (e.g. listening skills, educational skills), expert patients bring a strong added value to health management teams by providing information, advice and mediation between the medical knowledge and patient experience. The synergy between medical team and expert patients and a solution plan tailored to each individual sufferer helps accelerate patient rehabilitation.



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Improving pain management – delivering results in best practice cooperation models

Relieving persistent pain, improving health outcomes

Roger Knaggs, School of Pharmacy, University of Nottingham, UK

Gerhard Mueller-Schwefe spoke about Integrated Pain Management, which is a model where back pain patients, who are considered one of the most expensive groups of patients in our healthcare system, are integrated at a very early stage into a multi-modal pain programme.

The focus of Roger Knaggs' presentation was community pharmacists. Almost 90% of all pharmacists in the UK have a direct link with their local communities. Knaggs considers these health professionals an untapped and underutilised resource in helping support the management of pain sufferers. "Community pharmacists are one of the most accessible healthcare professionals for the public", he told delegates. "Pharmacists, working in collaboration with doctors and other healthcare professionals, have an important and expanding role in optimising the use of medicines and in supporting better health."

Knaggs believes medicines have the potential to transform people's lives, add enormously to life expectancy, and may transform health service outcomes and delivery. Analgesics are prescribed frequently for the management of chronic pain, but sub-optimal and sometimes inappropriate use of analgesics has been documented among chronic pain patients. A recent survey in the UK (NHS Information Centre 2010) suggested that over 10% of patients who were prescribed analgesics did not actually take them. They were never used.



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Knaggs went on to describe how pharmacist-led interventions could promote the safe and effective use of medicines, both those bought over the counter by consumers and prescribed analgesics. “Clearly, if we can help to support the use of these medicines in a more appropriate way and be a source of information for patients, this will help reduce some of the spiralling costs”, he said.

Community pharmacies are extremely accessible. In the UK, almost 99% of the population can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport. Pharmacies are open at times which suit patients and they provide a convenient and less formal environment for professional advice. Also, as more and more medicines are available without a doctor’s prescription, it is the community pharmacist who will be there to provide support and advice to patients buying medication over the counter.

Knaggs also believes an increased use of pain assessment tools may assist in identifying individuals who are “at risk”, and in finding early stage persistent pain cases. One of those tools referred to was a questionnaire with eight “Less Pain” questions, which as Knaggs told delegates, the community pharmacist would use to find out more about a patient’s current state and their treatment. “This is an opportunity for pharmacists to have a structured discussion with patients about their condition and the impact it has on their lives”, he said.

Knaggs is convinced community pharmacists have the knowledge and ability to play a key role in supporting patients, as well as extending access to effective pain relief.



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WORKSHOP 3

Improving pain management – delivering results in best practice cooperation models



Pain as the fifth vital sign in Galicia: Overcoming the challenge

Dolores Martin-Rodriguez, General Department of Quality Programs and Healthcare Safety, Galician Ministry of Health, Spain

Dolores Martin-Rodriguez began by referring back to 2010 when the Galician Health Service (SERGAS) initiated an integral pain care programme called “Strategy SERGAS 2014” to improve public healthcare and patient services in general. Its aim was to improve care for in-patients by implementing a standardised and affordable (global) strategy directed towards optimum pain management for all patients, thus achieving pain-free hospitals.

In 2011, pain evaluation as a fifth vital sign was implemented in all 15 hospitals belonging to the Galician Health Service. Standards were set and a management contract signed by all of the hospital directors with the objective that 50% of in-patients would have a pain evaluation register in their vital signs chart.

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Integral Pain Care

Pain Origin (N=22 112)		Associated Symptoms (N= 22 037)		Pain Location (N= 22 112)	
Other	13,4%	weakness / paresthasias	3,5%	Various locations	7,4%
Trauma	14,4%	Infection signs	3,0%	right leg	9,4%
Medical condition	34,4%	hematoma / hemorrhage	1,7%	left leg	9,7%
Surgery	15,3%	Fever/Sweating	2,5%	Abdomen	36,1%
Immediately after surgery	8,7%	Sweating	2,9%	Right upper limb	4,0%
Therapeutic Procedure	3,8%	Diarrhea/Nausea/Vomiting	0,8%	left upper limb	3,6%
Diagnostic Procedure	1,0%	Nausea / vomiting	5,7%	Back	8,0%
Not applicable	8,9%	Diarrhea	1,0%	Chest	7,2%
		No	78,6%	Head/Neck	12,0%
				No pain	2,6%

According to Martin-Rodriguez there were almost 221,000 hospital patients registered last year in Galicia. Pain was registered as a fifth vital sign in one-third of those patients. More than thirty percent had pain due to a health illness and almost 80% had localised pain in and around the abdomen. Head, neck and back pain made up 20% of this cohort. Pain ceased with analgesia in 45.6% of patients and diminished in 32.2%. 3% required rescue analgesia.

Nearly one third of all in-patients suffer from pain, although this figure increases in women over 60. Spain's pain evaluation procedure has allowed health professionals to become aware of the real situation and thus put forth actions in order to improve health care procedures.



Lars Bye Møller
FAKS

Erika Folkes
Eurag Austria

Martine Chauvin
AFVD

WORKSHOP 3

Improving pain management – delivering results in best practice cooperation models



A story about how patients and practitioners improve their quality of life using an Electronic Unified Clinical Record called Osabide Global

Dr. Enrique Bárez

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Enrique Barez, Medical Director, Pain Clinic, Hospital Universitario Araba, Spain

Enrique Barez reminded delegates that nowadays the use of IT as a means of communication between doctors and patients was a reality. “Everything works with one click!”, he said. Barez went on to describe how the lives of patients with chronic pain and those in the medical profession had

improved in the past two years due to the introduction of an electronic medical record, Osabide Global (OG), the Electronic Unified Clinical Record, developed by the Department of Public Health in Bilbao (Osakidetza).

This tool allows medical professionals from the hospital in the province of Araba in Spain’s Basque country to share important information about their patients. Barez believes this clinical record is better than what has come before. “In the past records were disorganised and not patient-centred,” he told his audience. “Now data has been unified and everything revolves around the patient, not the doctor.”



Anna Rosbach
Danish Member of European Parliament



Robert Johnstone
International Alliance of Patients' Organizations (IAPO)



Harald Stock,
CEO Grünenthal GmbH

The hospital's pain unit is actively using this new form of medical assistance and Barez claimed that as the ability to share information was just one click away, the amount of wasted time had been almost reduced to zero, creating non-face-to-face consultations. More than 1,000 such consultations had been carried out over a twelve month period using the telephone, web cams and video-conference facilities. The aim was to avoid an inconvenient trip to the hospital for patients and improve the time used to attend to their needs. Nurses, doctors, psychologists and pharmacists were just some of the professionals in this multi-disciplinary field who were able to access and contribute to the medical notes of patients. This clinical records tool not only creates an up-to-date information base, but it allows co-operation between primary and secondary care.

Satisfaction questionnaires showed 93 % of the patients felt comfortable and better informed with this form of healthcare provision. All patients thought their quality of life had improved considerably, as they avoided unnecessary trips to health centres and minimised the amount of time away from the workplace. Professionals also thought there was clearly a type of patient for whom the use of non-face-to-face attention was more practical.



WORKSHOP 3

Improving pain management – delivering results in best practice cooperation models



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Multidisciplinary approach to palliative care: Our experience in Valencia

José de Andrés, Palliative Care Programme, Valencia, Spain

José de Andrés described how the health care authority in Valencia had tried over the past twelve months to set out its own Road Map for Action to make pain management a top priority, while also installing two separate, but interactive, networks between palliative care and pain management. According to data from the Mortality Registry Valencian AR., the number of deceased persons in 2007, capable of receiving palliative care, was 16,927. 80% of them had suffered some form of pain in the final phase of life.

A working group in pain management was formed with the aim to improve the quality of life of citizens in Valencia. The objective of this project was to promote the management of pain in both cancer and non-cancer patients using a multidisciplinary approach with appropriate and timely use of interventional pain management techniques to provide satisfactory pain relief. A comprehensive palliative care plan had already been installed in Valencia in 2010 with its focus on patient autonomy, the integrated care of patients and a training and support programme for health professionals.

A pain management strategy was developed for the 23 healthcare departments in Valencia to run parallel with the palliative care plan. The aim was to create a synergy between the two teams. The specialised treatment of pain was integrated into the palliative care plan. This strategy, or Road Map for Action, included basic training in both areas for all health professionals, it encouraged the development of clinical sessions for interdisciplinary analysis of cases and established health care circuits based on the complexity and needs of the patient. It was also important for the public to understand that this synergy between palliative care and pain management was the health authority's commitment to quality.

Most importantly for both teams, it was made clear that pain should be treated early to prevent further morbidities. However, although health professionals were encouraged to adopt chronic pain treatment strategies early in the process, there were no prescriptive rules set down as to when a procedure should take place. It was down to the doctor and his team to decide.

The national rehabilitation guarantee

Anna Oestbom, Swedish Association of Local Authorities and Regions (SALAR), Sweden

In 2008, an agreement was made between the Swedish government and the Swedish Association of Local Authorities and Regions (SALAR/ SKL) to create a national rehabilitation guarantee. Anna Oestbom told workshop participants that its purpose was to support people with anxiety, depression, stress or chronic pain in shoulder, neck and back to return to work, thus reducing the amount of sick leave. The main goal was to reduce absenteeism due to musculoskeletal pain. Early intervention is also an important part of the guarantee. The budget allocated is 1 billion SEK, or 106 million Euros, each year. The government receives reports about the efficacy of the multi-modal rehabilitation programme four times a year, as it is important for them to establish whether or not the initiative is working and whether people are returning to work.

The Karolinska Institute in Stockholm, which is one of Europe's largest medical universities, was commissioned by the government to evaluate the project shortly after the initiative had been introduced, which as Oestbom said was "bad timing", as there was "not enough evidence to prove a change in absenteeism". But the longer the guarantee has existed the lower the sickness absence has become after rehabilitation. It is now clear that the working ability and health assessment of individuals can improve after six months.



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WORKSHOP 3

Improving pain management – delivering results in best practice cooperation models



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How can society help people get back to work?

Clairy Wiholm, Programme Manager, National Agency of Social Insurance, (REHSAM), Sweden

In 2008 and running parallel with the launch of the National Rehabilitation Guarantee in Sweden, the REHSAM research programme was initiated, which focuses on rehabilitation and collaboration. Its aim is to identify the best methods to keep two groups of people in work; those who suffer from pain e.g. non-specific back pain and those who may have mild or moderate mental health issues.

REHSAM grants are administered by the Swedish Social Insurance Agency and currently 24 research projects are running in Sweden. Of these 24 projects, 12 are focusing on employees returning to work after a long-term pain issue and the other 12 projects are focusing on the return to work of employees who have suffered from depression, anxiety, burnout and stress syndrome.

Many different projects are being funded, two of which are: neck-specific training for people with chronic whiplash associated disorders and early workplace-based preventative intervention for pain-related disability. Some projects are carried out in the workplace and most participants will have been referred by their GP, but there are also projects in special pain units. REHSAM is keen to establish networks nationwide, as it is believed this sort of collaboration between researchers, practitioners, decision-makers and the county councils are great motivators and will help facilitate implementation at a later stage. Projects are funded for two years and should include a twelve-month follow-up.

Wiholm told delegates that in the three years since the launch of the project, REHSAM had generated value both to the field of research, as well as to the clinical practice of rehabilitation. Funding for up to 80 million SEK (9 million Euros) has so far been allocated to the regions to cover costs of these research projects.

„Certain themes emerged from the workshop. Alternatives to traditional models of care are becoming evident across Europe and are already showing improved outcomes for both the medical profession and patients. People are being empowered to take self-care more seriously. As health professionals become better educated in the area of pain, there are obvious signs of better cooperation between clinicians and patients. Although the initial outlay for some of these initiatives may seem expensive, overall costs are being reduced in the long run. For example, in the Basque region of Spain, the cost of intervention is down, because much of the consultation work is done online, rather than face-to-face.

It is clear from the research carried out from Portugal to Sweden that patients are satisfied when their quality of life improves and care is centred on their needs. Health professionals are satisfied when they have the chance to work in a multi-disciplinary set-up, where each contributes equally to the well-being of a patient. And commissioners, employers and politicians are reassured, because the various pain initiatives have proven to reduce costs and improve outcomes. As a final note it was felt that there was still a need for more of these best practice models to be universally adopted”.



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Improving pain management – delivering results in best practice cooperation models



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Benchmarking, education and research programmes on pain management in the European Union

**Presentation: Rik Torfs, Katholieke Universiteit Leuven, Belgium
Pain and Social Affairs**

Pain as a part of life

There will always be pain. It is impossible to rule it out. The question though is not how to eliminate it, but how to make life liveable with not too much pain. That is a more realistic ambition politically speaking, but also emotionally. Politicians are known to speak, and even talk publicly, about the need for “zero road accident victims a year”. Zero? It is impossible. As long as there are roads, there will be accidents and society needs roads. The

same is true for pain. It cannot be eliminated, so life with pain should be made liveable. And that should already be considered quite a success.

Physical pain

The second point is the issue of physical pain. Ultimately, physical pain, in its deepest form, is stronger than mental pain. Great philosophers have long discussed the fact that physical pain at its most intense can cause mental pain to disappear, or current problems to become less important. It is as though deep down people think they should be more influenced by what touches the heart, and not so much by what is felt physically. This is an important issue, because society does not fully realise how physical pain influences one’s thinking, sorrows, intellectual depth and, of course, one’s ability to function in society.

Mental pain

The third point focuses on mental pain and, in particular, its connection with physical pain. People lead, on the whole, vertical lives with various ups and downs. The focus is on having a career and being promoted. Failure is frowned upon. All this is very human. Society does not believe in moving horizontally. Its citizens should always be looking to improve their lot and move forward. There is a vision for the future. People are doing well and feel young and vibrant. But then those very people start fearing the future. How might life change in the coming years? How will physical and mental pain impact on their lives?

There is the fear of decline. A very important element to all this is that people today are psychologically influenced by what may happen in the future, by their future perspective. And if they have the impression that one day they will be excluded from society, because they are becoming too slow, or have too much pain, or are not entirely in line any more with new requirements, then the weakness may already be felt right now. The idea of future pain can be psychologically very burdensome today. It forms a kind of circle, where the thought of physical pain and suffering in the future can cause mental pain in the present.

Social pain

The fourth point is social pain and the negative attitudes that people who suffer from pain face. Pain is not something easily recognisable and tangible for those not suffering. Pain is too elusive. There is no recognition, no official status. People suffering from pain can feel abandoned socially, because pain is very difficult to identify. Another element of social pain is the hypocrisy. When a person is young and critical, people say, "Oh, that young person has a critical mind. Society needs people like that." But making the same critical comment in old age earns the label, "grumpy, old man". And this is the problem as suffering from pain can lead to being called a grumpy, old man. This is because the disease, or the symptom, is not noble enough. A low social status of pain is not good for society and people should be made more aware of this.

Leading a healthy life

The fifth and final point looks at quality of life harmoniously going together with a long and healthy life, not riddled with excruciating pain. The political option for the future could be the choice between the right to live and the right to rest. Politically it is quite an issue. Many people want to take early retirement. But what does retirement mean? What does it mean resting? It is fine for one or two days, maybe even a couple of weeks, but what about two years or twenty years of full rest, pure contemplation. Of course, it might be possible to gain tremendous spiritual depth, but it is probably even too long for people gifted in that way. Society should not opt for the right to rest, but for the right to live, which could also keep people professionally active, if they wanted, and even beyond the age of retirement. Choices have to be made between investing in a lot of pensions and retirement money and investing in health care in the very broad sense, where people live well for a very long time.

WORKSHOP 3

Improving pain management – delivering results in best practice cooperation models



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Presentation: Kris Vissers, University Medical Centre Nijmegen, Netherlands

Education and research: deliverables

Basic principals

Education and research programmes on pain management in the EU are a very important pan-European benchmark and are a priority of the SIP Road Map for Action. They raise awareness for an improved management environment at national and EU level and identify best practices and certification standards.

Within this field, there is a need to look at the multidimensional aspects of acute and chronic pain, as well as proactively encouraging the multi- and interdisciplinary team approach in relation to patients' needs and problems. The language used should be accessible to all nationalities, while still maintaining high standards of evidence-based research. Studies should be guided by specific outcome measurements, in order to make the necessary adjustments, if the outcome is not what was expected. Prevention also plays an important part. Health professionals should learn from good practice and the public should be kept up-to-date with the progress being made.

There is strong interaction between patient care, research and education, and one should constantly feed into the other. However, this is not always easy, as most people work in a micro-environment with realistic situations, yet encompassing this is a macro-environment with its own social influences that impact on ones actions. It is no surprise there are situations in society difficult to control. This fact should be used to assess its impact.

Realised deliverables

There are already excellent examples of education in pain medicine. There are EFIC pain schools in Klagenfurt in Austria and Montescano in Italy, where students learn how to diagnose pain in detail. There are e-learning modules, some of which are in the early stages of offering self-management programmes for patients. There are many proposals on offer, but there is still a lot of work to do in finding common standards and practices.

On the whole, there are some exciting and innovative projects being initiated. Students can enrol on a patient-centred education programme at the Yalta Pain School. Much of the training is practice-based and there are opportunities to improve communication skills working with actors and video technology. These are hands-on courses, because health professionals want to immediately transfer their newly acquired skills into the workplace. There are grants available for fellowships and training at accredited pain centres. Israel and Turkey are two pioneering nations when it comes to pain and have made the role of a pain specialist a reality. Many more countries are following in their footsteps. However, most importantly, every form of learning should be practice-based using new methods and technologies, which is not always easy for an older generation of professionals who have not grasped the power and influence social network platforms e.g. Facebook, You Tube and Xing, as well as, Twitter, can have.

Areas “under construction”

Many projects could be considered “work-in-progress”. There have been a series of discussions to establish an accredited European core curriculum in pain medicine for under- and post-graduate levels, as well as a specialist training programme. Talks are ongoing, but the plans have yet to be approved. Courses would be designed for physicians, nurses, psychologists, physiotherapists and occupational therapists.

There should be a clear distinction between standard and specialised pain education programmes. The family doctor is very often the first port of call for the majority of pain sufferers and it is the GP who remains in close contact with the patient throughout the process, so those working in primary care should receive a basic training in pain. Specific information and educational tools should be designed for patients and their proxies. A clear outline has been drawn up for each of these initiatives. The next stage is to take them onto a European level and allow communities to share experiences, celebrate best practices and learn from each other.

WORKSHOP 3

Improving pain management – delivering results in best practice cooperation models



Areas still to be realised

Although much has been achieved, pain education still has a long way to go. What should be realised for the future? There could be more collaboration with pain-related societies like the World Institute of Pain (WIP), the European Society of Regional Anaesthesia (ESRA) and the European Society for Neurology (ESN), to name just a few. There should be a description of multidisciplinary competences within a core curriculum. Mono-disciplinary competences are known, but what about multi-disciplinary competences. How should pain teachers be taught? A teach the teacher programme may make it easier to recognise who is most suited to work in the classroom. Can a good clinician be a good teacher? Not always. Webcasts of teaching courses would help external students. There needs to be a full multidisciplinary accreditation system, which makes it worthwhile for a doctor or health professional to participate in the teaching process course and exchange experiences on a professional level. Finally, the goal should be to establish a pan-European, collaborative educational programme.

Realised research programmes

There are several good examples of collaborative research groups e.g. the EU's Sixth Framework Programme (FP6) and the German Research Network on Neuropathic Pain (DFNS). The SIP platform and the recent launch of the SIP Roadmap have contributed to the realisation of several studies. The Seventh Framework Programme (FP7) is on target with basic and clinical research proposals, as well as open clinical trials in pain, as part of the programme. There are also grants available. The European healthy ageing system is up and running and is getting positive feedback. Finally, there should be specific programmes for indicators to measure and assess if what is being done is good, or not.

Improving research outcomes

Planning is vital to avoid the various research programmes covering the same ground. A European Research Institute could have an overview of commissioned work and act as coordinator, while a European Observatory on Pain would measure what is being done, how it is being done, outcomes and future planning. Outcomes, structure and process indicators are very important. A further important issue is securing funds, donations and grants.

Final points

It cannot be denied that a lot has been achieved in the field of pain education and research, but a lot more still has to be done. Pain and SIP should be on the agenda of national and international institutions. Pain comes at a high cost to society and should be considered a major societal health problem. There is a real need for stability in funding for research and education and pain care. Finally, high-level, accredited pain education should be implemented in academic and professional organisations to create a joint venture between public and private enterprise.

WORKSHOP 4

Benchmarking, education and research programmes on pain management in the European Union



Benchmarking, education and research programmes on pain management in the European Union

Reporter: Pete Moore, UK

Introduction

For future sustainable understanding and awareness of the Societal Impact of Pain, an environment supportive of pan-European benchmarking, training and certification standards in pain management, education and research needs to be ensured. The “SIP – Road Map for Action” places education and research as a priority to raise awareness for an improved pain

management environment at national and EU level. In Workshop 4, participants exchanged best practices of current international benchmarks, as well as educational and research programmes in pain management.



Coaching chronic pain

Jan van Emelen, Independent Health Insurance Funds, Belgium

Jan Van Emelen began the workshop with an outline of the work the Association Internationale de la Mutualité has been doing in the past year to coach patients to self-manage their chronic pain. Van Emelen has spoken at previous SIP meetings about how insurance companies had recognised that early support could help patients self-manage their condition, which would free up more time and resources for health care professionals.

Van Emelen described the aims of the project and some of the issues that arose from self-manage initiatives, which included coaching, motivational interviewing by phone and self-measuring. He went on to explain how the Association Internationale de la Mutualité was now looking at a similar project for Diabetes type 2 cases in Belgium, as well as introducing a Randomised Controlled Trial (RCT) for this health condition.



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WORKSHOP 4

Benchmarking, education and research programmes on pain management in the European Union



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EFIC education and research programmes

Martin Koltzenburg, EFIC, UK

Martin Koltzenburg gave a broad overview of the structure of EFIC, what it is and what the organisation does. EFIC organises bi-yearly pain conferences in Europe. The aim of these conferences is for health care professionals from different fields of pain to meet, swap ideas and support the next generation of pain specialists. Webcasts of plenary sessions are also available.

There is sponsorship money for 10 lectureships at international conferences and EFIC also offers research support via research grants for clinical and human experimental pain research. These biennial grants totalling up to 200,000 Euros support young scientists early in their career to carry out

innovative clinical pain research in any member country of EFIC. Individual research grants are valued at up to 40,000 Euros per project and the duration of each study should not be longer than two years. Research grants are intended for clinical and human experimental pain research only. Proposals to use animals, computer simulations, cell lines etc. are not considered. The decision of the awards is made independently by the EFIC Sub-Committee on Research.

There are also Pain Summer Schools for health care professionals working in pain to increase their knowledge of latest developments in pain medicine and pain management. EFIC's Pain Schools are in Klagenfurt, Austria and Montescano, Italy and have been widely recommended by many in the pain community.

Koltzenburg finished his presentation by setting out EFIC's plans over the coming months to further support health care professional training. Web-based, e-learning programmes are being developed, as are webcasts of teaching courses and there are plans for travelling lecturer courses for pain sciences.



WORKSHOP 4

Benchmarking, education and research programmes on pain management in the European Union



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Chronic pain and therapeutic patient education – is it useful?

Françoise Laroche, Cercle d'étude de la douleur en Rhumatologie (CEDR), France

Françoise Laroche began her presentation by putting some intriguing questions to the workshop participants about why most pain management programmes were fixated on one particular form of treatment without asking, “What actually works for whom?” and “What kind of patient can improve the best?”

Laroche continued by giving an overview of forty studies that looked at the effects of chronic pain in multidisciplinary interventions and psycho-education projects. This research involved 4,781 patients and formed the

Cochrane database (Eccleston C, Cochrane Database 2009). The results showed positive, but small, effects with patients describing improvements in pain intensity, cognitive behaviour and health-related quality of life.

Laroche went on to talk about patient selection and the importance of taking the time to best match a particular type of intervention to the characteristics of each individual patient. This method of pain management, which went under the title “What works for whom?” was received positively by the workshop participants. It was clear the majority preferred this approach to a “one size fits all” system.

Having grabbed the attention of those in the room, Laroche described the process at her pain clinic in France, which picks out the most appropriate patients to match a particular pain programme. Most participants suffer from low back pain and fibromyalgia. There are 8 weekly sessions with each lasting two and a half hours. Work groups are made up of between 5 and 8 patients and are based on education, cognitive behavioural therapy (CBT) and physical exercise. The outcome measures used include the Patients’ Global Impression of Change (PGIC), the Visual Analogue Scale (VAS) and the Dallas Pain Questionnaire. The content and outcomes are those expected when patients attend a pain management programme.

Laroche described the “zero” session, which helped with the patient selection process, as it set out clear parameters for the programme. Participants had to be actively involved, agree to the agenda, understand the tasks planned for them and have a good reading ability. These are multimodal interventions where both the patients’ and the therapists’ goals and expectations are the same.

Laroche closed her session with the suggestion that perhaps patients could attend one or two motivational sessions prior to attending a pain management programme, to ensure the right patients were selected for the programme. I enjoyed this session as did others in the workshop, as it made many stop and think about making sure the right patients were signposted to a pain management programme and more importantly, were motivated to learn.



WORKSHOP 4

Benchmarking, education and research programmes on pain management in the European Union



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Pain Medicine in Medical School curricula

Andreas Kopf, Klinik Benjamin Franklin, Germany

Pain education for doctors is fast becoming a hot topic and there is much debate about the lack of knowledge GPs and other health professionals have when talking about pain. This point was highlighted at the UK Pain Summit in November 2011 when a pain doctor said that veterinarians received more pain management education than a doctor who saw and treated people on a daily basis.

“Veterinarians receive more pain management education than a doctor who saw and treated people on a daily basis.”

Andreas Kopf began by offering one reason why this might be the case, “Unlike high-tech medicine, pain treatment lacks glamour”, he said. Kopf suggested a general pain medicine curriculum, which might be more appropriate for GPs. It would include basic, essential knowledge and recommendations from academics for further study. It should not be a comprehensive, time-consuming and textbook-based pain management programme. There were also questions raised about where this training should be carried out. It is clear though, pain management is required by every clinical working physician and every medical school graduate should be able to identify most patients with chronic pain and know how to refer them according to their needs.

Kopf went on to state that universities and medical faculties around Europe and in low resource countries needed to enhance and modify their pain education modules to increase interest from trainee doctors to learn. He suggested using a modified Europe-wide master curriculum, like that designed by EFIC, which would suit the requirements of each country. He also called on nations to identify local champions “to move educational initiatives along”.

Kopf concluded reminding delegates that most physicians would be confronted with pain management and that no medical graduate should leave medical school without general knowledge in pain medicine. Pain medicine should also not be seen as an isolated topic, as it is “well-suited for blended learning and other advanced medical education tools.”

Developing Pain Education for nurses by nurses

Manuela Monleón and Marta Pisano, Federación de Asociaciones de Enfermería Comunitaria y Atención Primaria (FAECAP), Spain

This was a joint presentation by Manuela Monleón and Marta Pisano from Spain. It is well known that Spain's economy is suffering at the moment, which, according to Monleón and Pisano, is having an impact on the performance of different health systems.



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In relation to safety care the women described two safety studies of the health system that were carried out in 2006 and then two years later in 2008. The focus of the second study was in primary care. Both studies concluded there was a need to improve the training of professionals, especially in skills and medication management, as well as in promoting teamwork. In recent years teamwork has become a hot topic, not only between health care professionals, but also between health professionals and patients.

Further data published in Spain in 2007 revealed that 80% of pain patients were unhappy with their treatment, which had an impact on drug consumption and how involved they were in the process. This figure was over 90% for those over 75 and the main complaint was "not being listened to". The question was put: "Are we diagnosing and treating pain?" It would seem not.

WORKSHOP 4

Benchmarking, education and research programmes on pain management in the European Union

Monleón referred to a study by Dr. Linda Aiken, professor of nursing at the University of Pennsylvania, where she concluded that there was a parallel between the education level of a nurse in pain management and the improvement of a patient's condition. Years of nursing experience did not influence the patient's improvement, however an increase in nursing education did.

Monleón reminded delegates of the important role nurses played in pain management. "The nurse is the professional who spends most time with the patient and with family care,

"With a strong knowledge-base nurses could make recommendations about medication, dosage, and possibly other complementary, non-pharmacological methods."

using analgesics and others drugs, non-pharmacological treatments, and educating the patient in self-care of their pain", she said. She stressed that with a strong knowledge-base nurses could make recommendations about medication, dosage, and possibly other complementary, non-pharmacological methods. Monleón concluded by stating that there needed to be a more rigorous approach to pain education for nurses. On a positive note, progress is being made in developing an online training course by nurses for nurses.



SIP

Societal Impact of Pain

Abstract & Background Booklet



WORKSHOP 4

Benchmarking, education and research programmes on pain management in the European Union



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Pain Forum for Patients

Maria Dolores Navarro, Patient University, Spain

Maria Dolores Navarro began by outlining the characteristics and challenges facing health care systems. Issues related to the complexity of the process of care are the fact that there are different models and disciplines used across countries. One of the biggest challenges facing health care systems is the changes taking place in society, for example: an ageing population, lack of resources and the level of education.

Navarro also described the importance of internet search tools for patients to source information about pain. She explained how there were more than 39 million sites referring to osteoporosis and a staggering 698 million sites for cancer. The word “pain” displays more than 900 million sites in 0.12 seconds on Google’s search engine. This is an astounding number of sites offering, and sometimes selling, support for pain issues.

Social networks are also a platform to give pain patients a voice. Recent research (Torrente et al, 2010) showed social networks offered people support groups, a place to exchange information, share feelings and give emotional support. Navarro went on to describe the interacting factors that influence health, which included lifestyle and socioeconomic status.

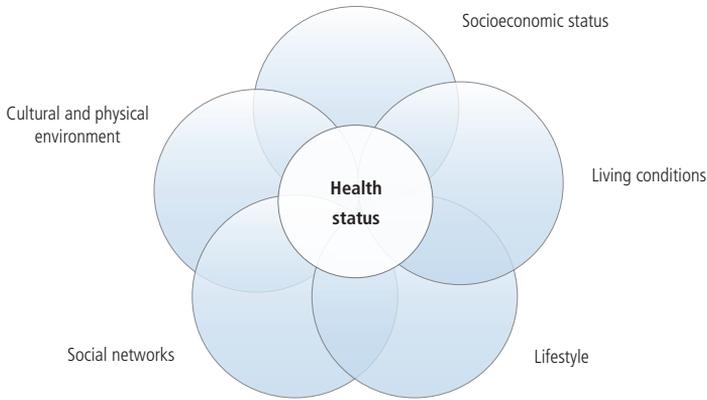


Hans Georg Kress
President EFIC



Hilda Wieberneit
Pijn Platform Nederland

Factors interacting to influence health



The direct impact of pain includes a possible limited capacity to function normally and a dependency on care, which affects one's quality of life. Pain has an indirect impact on family and friends, as well as on the work and social environment. Navarro's closing message was familiar to what has often been said by patients and the organisations that represent them. She suggested we needed more patient participation in the decision making process, more patient representatives and more education. "There is a need to continue increasing access to information", she told delegates, "Because only then will patients transform from being passive to active citizens."



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WORKSHOP 4

Benchmarking, education and research programmes on pain management in the European Union



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Improving chronic pain Management through integrated care processes, training program in primary care and quality sign: “Centres Against Pain”

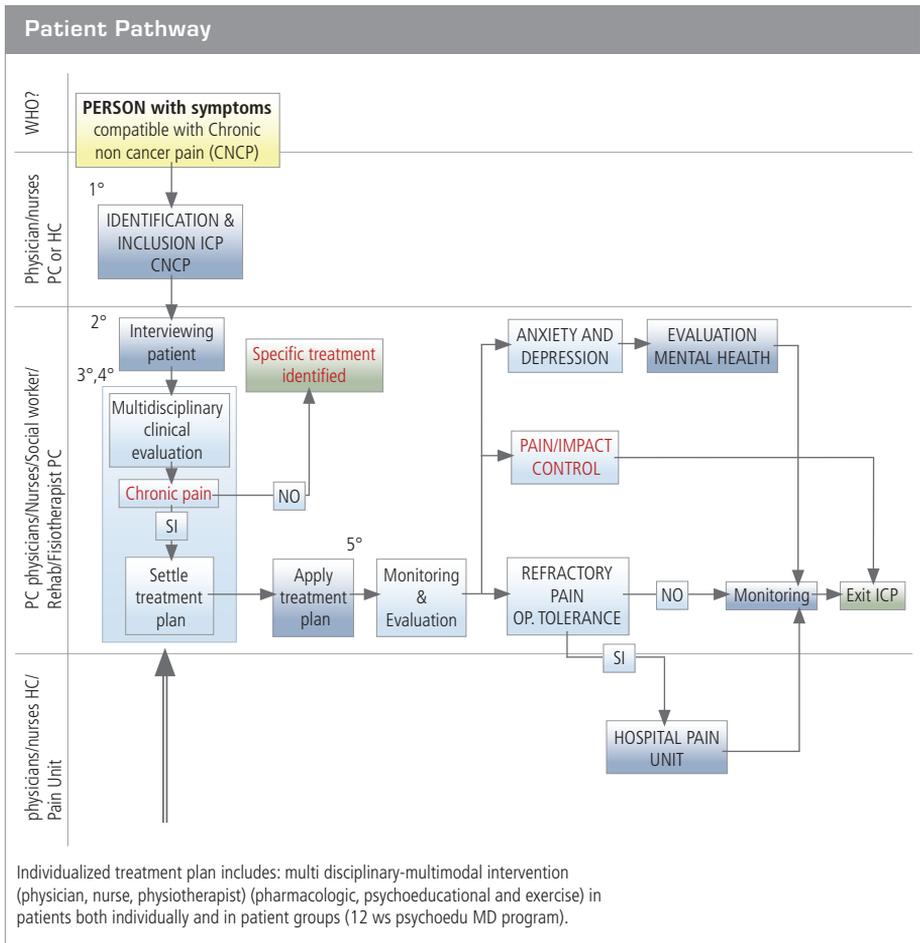
Juan Antonio Guerra de Hoyos, Andalusian Plan for the Attention of People with Pain, Spain

Juan Antonio Guerra de Hoyos gave an interesting introduction to his Andalusian Care Plan for People in Pain presentation by highlighting some of the project's main developments to date, which included: training programmes for health professionals and opioid guidelines.

The road map began in 2005, when health and quality plans led to the development of several integrated care processes, including chronic pain, palliative care, fibromyalgia or surgical patient care. By 2010 two integral care plans had been implemented: one on palliative care, the other on pain.

But for Guerra de Hoyos the masterpiece of this health care project has been the Andalusian Caring Plan for People in Pain (ACPPP), which is a three year project and was implemented in 2010. This is a comprehensive plan, which takes into consideration not only chronic pain, but also peri-operative, procedural and/ or acute pain in emergency care settings, always with a special emphasis on particularly vulnerable patients like children, the elderly and mentally ill or disabled people.

Guerra de Hoyos went on to explain the main developments of the plan to date, such as new Integrated Care Processes (ICPs), guidelines on opioids, training programmes for physicians and nurses, and the quality sign centres against pain. A new patient pathway on ICP chronic, non-cancer pain was introduced. Patients are evaluated in primary care facilities before a care plan is put into action. There is also a multidisciplinary team that applies pharmacologic, psycho-educational and exercise-based interventions, both for individuals and patient groups.



Guerra de Hoyos also described the latest developments, which are Centres Against Pain, as a sign of quality, which can be accessed online. Several primary care centres and hospitals have already been recognised as quality care centres. The programme is suitable for any kind of centre of the Andalusian health service. It is fully compatible and integrated with the existing accreditation system for centres and professionals and it offers a guided voluntary procedure, which includes a self-evaluation phase and an external audit phase. It also consists of three levels of compliance, which leads to a road map for excellence.

Looking at the year ahead, Guerra de Hoyos said Andalusia was planning to incorporate indicators of health outcomes, aspects of attention to pain and improvement goals in the portfolio of health facilities. There are also plans to continue with training activities, to introduce a pain taxonomy and further develop the content of the expert pain programme.

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Galician School in Public Health for citizens: Education in Pain

Begoña García Cepeda, General Department of Quality Programmes and Healthcare Safety, Galician Ministry of Health, Spain

Begoña Garcia Cepeda comes from Galicia. She began by giving an overview of this region in north-west Spain. Galicia has a population of 2.8 million with one-fifth 65 or older. The health system is made up of 15 hospitals with more than 8,000 beds. There are 391 primary care centres. In 2011, there were 240,000 hospital admissions, 200,000 surgical interventions and 15 million primary care consultations.

The Galician Health Service is an independent public organisation and has a 5-year strategic plan. One of its strategic points is patient and citizen participation, in order to encourage their empowerment, while ensuring

transparency and sustainability of the health system. Garcia Cepeda explained the strategy regarding the Galician School in Public Health for Citizens, which is a knowledge-based network and offers training in self-care and care for chronic patients, in order to make people aware of their co-responsibility in making medical decisions and to increase health literacy levels. More than 3,500 patients have been trained there since 2009. Over 1,000 healthcare professionals have collaborated as educators and trainers. They have a very active and user-friendly website, where people learn about and sign-up for forthcoming activities, put questions on open forums, which get answered by experts, and view relevant documents and links to news feeds. Users can also put forward suggestions for their own educational or training needs.

So does it work? 112 workshops on different pathologies have been organised since 2010, but pain care is always the main subject or problem. Physicians and patients alike have participated in fifteen online forums and more than 4,000 patients and 1,200 healthcare professionals have contributed to the development of new guidelines. Four specific workshops on pain management (fibromyalgia, arthritis, rheumatism and oncology) have also been organised, where the main themes were: characteristics of pain; frequent causes and symptoms; therapeutic strategies. Survey results reflected a high degree of satisfaction (87.6%) and usefulness of what was taught (almost 90%). The teaching staff was considered to be outstanding. Almost 25% of the people acquired new knowledge about their illness and care. In my opinion, this was a particularly enlightening presentation, very inter-active and easy to understand. It showed how the Ministry of Health in Galicia had thought carefully about bringing together all the relevant people involved in health care, but most of all, how they have involved the patients in the decision-making process.

Hospital-territory without pain

Lucia Di Furia, Servizio Salute Regione Marche, Italy

Many of the workshop participants were eager to hear Lucia di Furia's presentation about Law Nr 38, partly because it is rare to hear about a government passing a law for pain. On March 15th 2010, Italy adopted the Law Nr. 38 "Disposizioni per garantire l'accesso alle cure palliative e alla terapia del dolore" (Provisions aimed at ensuring access to palliative care and pain therapy). The aim of pain therapy is to enable patients with chronic diseases to achieve pain control. Di Furia stated all citizens had the right not to suffer unnecessary pain during their lifetime and at the end of life. He continued saying, pain needed to be treated and the end of life period had to be included in the care process. Law Nr 38's main focus is on indiscriminate dignity and autonomy of patients, quality of life to the very end and patient and family support through health and social care.

"It is rare to hear about a government passing a law for pain."



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Di Furia was keen to outline Regional Law 892/11. Here, the Marche Region has approved a pilot project to create a structured pathway with the aim to improve pain relief care both in acute and especially primary care settings. More than 80,000 Euros have been allocated to the project, which aims to develop a care model which is able to guarantee health professionals and administrators within the hospitals of the Marche Region carry out both a systematic and uniform detection of pain. A coordinating group has been formed, partly to empower a designated structure to operate 24 hours a day to decrease the number of people who inappropriately access A&E.

It is also important to train personnel to prevent the under-estimation of pain, especially for people who suffer cognitive deterioration. Following the evaluation of the pilot project, the necessary modifications will be made, before extending the system into the entire region. The project is all about controlling pain and includes the launch of procedure pain management protocols for adults and children within the hospital.

Di Furia concluded by stressing the need to define a project which will safeguard both adult and child patients and identify pathways to improve pain relief treatment, both in acute and especially in primary care.

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Patient involvement in pain guidelines

Bébhinn NicLiam, Endometriosis Association of Ireland, Ireland (on behalf of Judy Birch, Pain Alliance Europe, UK)

A recent European Commission report (May 2012) stated that the term “patient involvement” was not clearly understood by both patients and practitioners, and often meant different things to different people. For many patients the term was a nebulous concept revolving around healthy living and being responsible for one’s own health. For both practitioners and patients it was often simply equated with medical compliance and following doctors’ orders. While patient involvement was often seen in terms of patients providing basic information on symptoms to a healthcare professional, it was less widely perceived to include a more interactive dialogue or opportunity for patient feedback.

The UK Department of Health has recognised that patient involvement has led to better outcomes, satisfaction, adherence and reduced costs. Patients also have a right to participate in health policy (Health and Social Care Act, 2008 & 2012).

“The UK Department of Health has recognised that patient involvement has led to better outcomes, satisfaction, adherence and reduced costs.”

Bébhinn NicLiam, who presented the final workshop on behalf of Judy Birch, explained that the policy statement on patient involvement of the International Alliance of Patients Organisations (IAPO) stated that patient involvement should occur whenever decisions are being discussed, which will affect patients’ healthcare or

lives. This involvement should occur during the design stage of: education and training programmes for health professionals, research and development initiatives, care and treatment guidelines. IAPO has also set down guidelines for patient involvement. The government has also recognised chronic pain as a long-term condition.

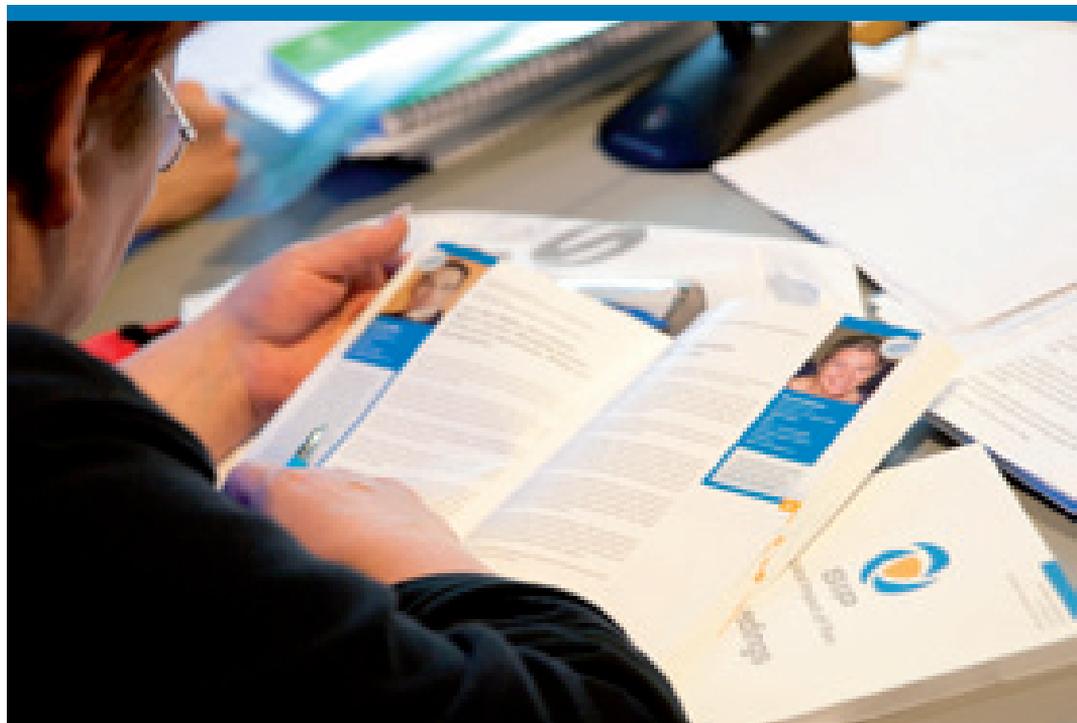


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NicLiam also described the Quality Standard for Pain being developed by the National Institute for Health and Clinical Excellence (NICE). These are statements about the care a patient can expect to receive. A guideline for pain management is to be developed alongside the standard. Patients and representatives of patient organisations have been invited to participate in their development. There is an application process for patient/lay membership of guidance development groups/committees. There have been concerns in the past about NICE's processes. It was felt there had been a lack of research evidence on patient/carer views, experiences and preferences. Quality of life measures were often determined by professionals and did not reflect issues of most importance to patients and the process did not account for wider societal costs.

NicLiam said it was crucial to involve all stakeholders to avoid the omission of important points. From a European perspective, it is important to be inclusive in terms of involving patients in all countries, of all ages, gender and all aspects of pain in the body should be taken into account, not just musculoskeletal and back pain etc. Summing up, NicLiam hoped the work of IAPO would lead to pain featuring more thoroughly in better quality guidelines. Likewise, there should be meaningful patient involvement in the areas of health professional education and research relating to pain.



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Establishing multi-stakeholder pain platforms in Europe

Presentation: Anton Herreos, Director of FUINSA (Fundacion para la investigacion en Salud), Spain

Plataforma SinDolor: 5 years of experience with a multi-stakeholder platform in Spain

Working together on a pain platform

FUINSA initiated its pain platform (Plataforma SinDolor) in 2008. The basic objective then, as now, was to make society aware of the importance of pain, not only in terms of doctors, but also nurses, chemists and governments, not forgetting the important role patients, the media, psychologists and all other protagonists in this multi-disciplinary approach play. No group involved has wanted to see patients suffer with pain. To

this end, every effort has been made to coordinate work across the spectrum amongst the various stakeholders.

Spain's political system is complex. There is a central government, but then there are seventeen different autonomous communities, where each is responsible for its own health policies. Spain's pain platform formed a committee of experts from different agencies, including: the Ministry of Health; scientific societies closely linked with pain; the Spanish Family and Community Health Oncology; the Spanish Pain Society; rheumatology; geriatrics; gerontology and finally, pharmacists, because they play, or can play, an important role in terms of this multi-disciplinary approach. Representatives of the health administration at central regional level, research quality training and care for the patient were also included.

The Foundation worked with patients, including some with fibromyalgia, who had been referred by the Spanish Forum of Patients. From the outset there was strong co-operation with the different regional health administrations. The expert committee drew up a list of the main focal points of the platform. One of those was awareness-raising initiatives; the other was co-operation agreements, where activities would be co-ordinated.

EVALualo

One of the most important campaigns during the last five years has been EVALualo, "Evaluated" in English, a three-prong initiative, which received widespread support and looked foremost at the importance of measuring pain, using the Visual Analogue Pain Scale, as part of the clinical record of a patient. A further aspect was directed at the patient, with the question, "Does it hurt?" appearing in published leaflets. The reader was then encouraged to consider a few points relating to his pain, e.g. its origin, location, intensity and how long the pain had been present. 375,000 leaflets and 3,800 posters were distributed nationwide. The campaign won a number of health awards, including "Best Health Campaign of the Year" and "Best Initiative".

Forums: meetings and conferences

Further aspects of SinDolor have been the organisation of forums and seminars. There have been annual national meetings since the pain platform's inception, covering topics from "Pain and dependency" to "Pain in the European environment". The media were particularly interested in "The patient and his or her pain", the topic in 2011.

Regional meetings with managers and experts from the 17 autonomous communities, which take place annually on World Day Against Pain, are also an important aspect of the platform. In particular, the working breakfast, which was first organised in 2010 and went by the title, "Two council members against pain". Ministers from two regional authorities demonstrated how they were actively involved in combating pain. Follow-up seminars have been held in 10 of the 17 autonomous districts, including Andalusia, Galicia and Valencia, and meetings are ongoing.

Publications are made available for those who could not attend the meetings and the platform continues to work closely with the media, sponsoring a journalism and pain award each year. And of course, Plataforma SinDolor has an active website.

Current challenges

Spain's pain platform is very much alive and active. The energy levels are so high it is as though it was Day 1, rather than Year 6. The next phase is to encourage more cooperation agreements, where regional health authorities describe the steps, challenges and strategic points in terms of their pain policies. Interestingly, the authorities in Murcia are developing a multi-factorial intervention to improve care for patients with chronic pain. The major challenge for the coming period is establishing guidelines for a plan ensuring equity for patients in terms of Spain's health structures.

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Conclusions

First of all, cooperation amongst all the stakeholders is possible. Spain's pain platform has proven this over the past five years. Organisations involved in the work have been sensitive to the issue of pain, which has made it easier to move forward. Government support has been vital from the project's inception to ensure its success. Government health administrations in Spain are aware of the pain issue and are acting on it. It has also been necessary to have a cooperation policy amongst all the stakeholders. Work is ongoing and whilst there has been a change to the approach towards pain in the past five years, it is necessary to continue coordinating work. A further success for the platform has been taking the issue of pain beyond pain circles and raising its profile within the health system and society, in general. Finally, the work of the pain platform is to ensure continuity and encourage long-term participation from all the stakeholders.

“Government health administrations in Spain are aware of the pain issue and are acting on it. [...] The work of the pain platform is to ensure continuity and encourage long-term participation from all the stakeholders.”

Establishing multi-stakeholder pain platforms in Europe

Erika Folkes, Austria

Introduction

In May 2011 the symposium “Societal Impact of Pain” took place in the European parliament. An important outcome of SIP 2011 was the SIP - Road Map for Action, which outlines the key issues on how the EU institutions and member states could effectively address the societal impact of pain at both EU and national levels. Since then in several European countries, representatives of key stakeholder groups have come together to discuss the national implementation of the objectives of the road map. The objective of this workshop was to discuss and share local and national best practices.

As a start, Co-chair Alain Serrie from the Hôpital Lariboisière in France introduced participants to the scope of the workshop, which was aimed at implementing the Road Map for Action in each country.



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The Road Map for Action and the Road Map Monitor

Rolf-Detlef Treede, Chair of Neurophysiology, CBTM, Medical Faculty Mannheim, Heidelberg University, Deutsche Gesellschaft zum Studium des Schmerzes e.V. (DGSS)



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The overview Rolf-Detlef Treede gave was at the same time an introduction to the topic of the workshop. Treede feels that a lot has been achieved since the EFIC Declaration in 2001. The National Pain Summit of IASP Chapters in 2010 resulted in the Declaration of Montreal, ensuring that access to pain management was a fundamental human right and therefore an obligation for governments and healthcare professionals (see Human Rights Watch www.hrw.org/en/node/81080). This was emphasised at the Societal Impact of Pain (SIP) Symposia in 2010 and 2011. However, Treede feels that EU policy action has not always matched these achievements in the past ten years.

An important outcome of SIP 2011 was the Road Map for Action, which outlines the key issues on how the EU institutions and member states could effectively address the societal impact of pain at both EU and national levels. The Road Map has been endorsed by more than 55 organisations with various interests across Europe, which reflects the broad relevance this document has for the European Union. Treede stated that “it is vital” to continue explaining the Road Map to national bodies, as many of them are responsible for financing research projects.

The ‘Road Map for Action’ outlines seven key policy dimensions on how EU institutions and member states can effectively address the societal impact of pain at EU level. It aims to provide politicians and health care decision-makers with a benchmark on national policy in pain care throughout Europe. Recognising the need for an improved pain care agenda, the European Road Map Monitor 2011, which is based on the ‘Road Map for Action’, has been developed to understand the key issues that need to be addressed to effectively tackle the societal impact of pain.

WORKSHOP 5

Establishing multi-stakeholder pain platforms in Europe

Preliminary results from this first European Road Map Monitor into pain care were presented in Hamburg (21-24 September) at the 7th Congress of the European Federation of the IASP® Chapters (EFIC®). These early findings offer a snapshot of how countries have addressed and implemented, nationally and internationally, the “Road Map for Action” for improved pain care in Europe.

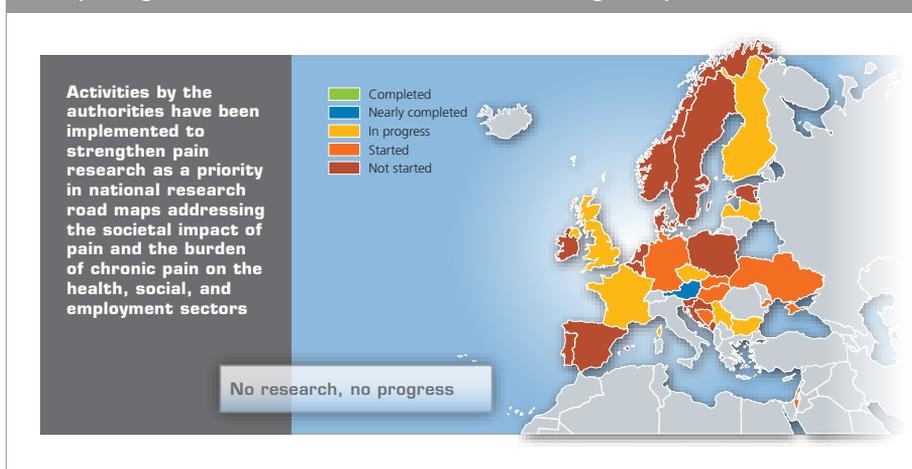
The study looked at the extent to which pain was recognised as a specific health condition. There were also questions about the status of mandatory teaching programmes on pain care and the existence of local stakeholder platforms sharing best-practice policies.

The preliminary findings from the European Road Map Monitor 2011 have reinforced many of the ongoing issues relating to the societal impact of pain. Although the majority of countries in Europe reported to be in the process of establishing some form of pain platform, the research revealed some of the unmet needs of chronic pain patients. It also showed there was inadequate knowledge and information about pain management and ten years on from the EFIC® Declaration of Pain, national and EU policy action had been very limited and was not adequately prioritised with governments and health providers in many parts of Europe.

The findings of the Road Map Monitor also showed that European governments generally lack commitment to pain research, which leads to an absence of a plan for chronic pain care, including early diagnosis and secondary prevention.

As a whole, there are large discrepancies between governments and the extent to which they recognise adequate pain care as a citizen’s right. In Denmark, patients now have the right to be treated within 30 days. In Italy, patients’ rights are guaranteed by a special Law, introduced in 2010. The Czech Republic has achieved a major breakthrough, where pain

European governments lack commitment to strengthen pain research



care is now considered a special discipline. Germany has installed mandatory teaching of pain medicine in medical schools and, as an add-on, training for all specialists with direct patient contact.

Among the biggest problems listed was insufficient financing (Czech Republic and the UK), unclear responsibilities (Denmark), lack of training of professionals (Portugal and Scotland/Wales) and missing epidemiological data (Ireland). At the same time, basic and clinical science have demonstrated the feasibility of pathways out of pain for many types of acute and chronic pain, but many health care systems currently do not guarantee general access to these. So far national action plans at governmental level exist in Portugal, France, Italy, Scotland and Wales. Treede called for National Action Plans against Pain being implemented across Europe.



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Multi-stakeholder Pain platforms within England – “Bringing people together”

Beverly Collett, Chronic Pain Policy Coalition (CPPC), UK

Beverly Collett who is the chairperson of the Chronic Pain Policy Coalition (CPPC) made it plain from the start she wished to see her initiative, “Bringing people together”, as a platform pushing for a chronic pain policy. “If you bring people together, they have a stronger voice”, she said. However, they have to be the right mix: people living with pain, policy makers, professionals and parliamentarians, although their thoughts are often on the next elections”.

The CPPC Executive Committee is composed of people representing different aspects: for example, charities and patient groups, as well as affiliates, such as the Royal Colleges of Anaesthetists, GPs and Nursing, physicians and corporate members, including Pfizer, Sanofi Pasteur and NAPP. “They all pay the same membership fee and get treated equally” she said, “The private sector is equally important to us, otherwise CPPC would not exist”.

CPPC lobbying has resulted in debates in the Houses of Parliament and the House of Lords and the Department of Health has shown interest. The biggest achievement so far has been the first Pain Summit, aimed at taking pain seriously, which was followed by three workshops on education, commissioning and public health. A final report is due in July 2012.

At present, CPPC is focused on ensuring the public understands chronic pain. “It is vital to involve all patients, improve the education of the general public, the media, graduates and undergraduates alike”, Collett concluded.

SIP in Slovenia

Nevenka Krcevski Skvark, EFIC, Slovenia

As a physiologist for some 30 years, Nevenka Krcevski Skvark has experienced a rise in unemployment rates and a decline in years of healthy living. 90 percent of the elderly now suffer chronic diseases, versus 70 percent in other generations. There is also a lack of epidemiological data on chronic pain in Slovenia. What is known is that more than 40% of the population is suffering. This number rises to more than 80 percent in nursing homes. The use of opioids is also rising.

While all hospitals have pain units for acute pain, there are no multidisciplinary pain centres in university hospitals and there is no specialisation in pain medicine. There is no National Plan in sight for pain treatment.

In October 2011, patients and healthcare professionals met in the Slovenian parliament to endorse the Slovenian Declaration for a National Plan for Pain Management. This was followed by a meeting of the Commission for Social

Protection, Healthcare and Disability in

“All countries in transition have the same problem: very frequent changes at the political level. [...] There is a clear and strong need for EU directives.”

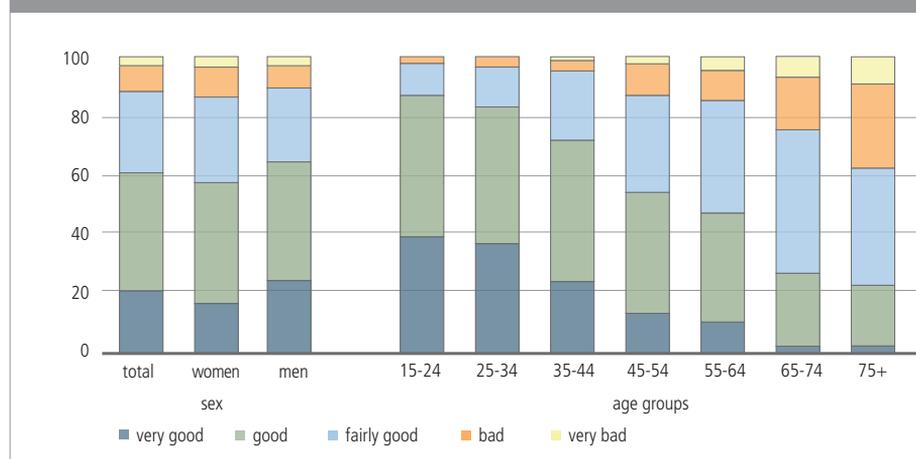
March 2012. Although the Ministry was advised to form a group for the preparation of such a plan, a change in Government made this impossible. “With new people” Krcevski Skvark feels, “you have to start all over again”. According to her, all countries in transition have the same problem: very frequent changes at the political level. Her conclusion: “There is a clear and strong need for EU directives”.



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General health status of the population by sex and age groups, Slovenia, 2007



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Pain in the Dutch “Regieraad” Report

Frank Huygen, Erasmus University, Rotterdam, Netherlands

According to the Dutch Council for the Quality of Healthcare there is a strong prevalence of chronic pain (CP) in the Netherlands, yet despite 2.25 million people suffering from chronic pain, compared to 1 million patients with coronary diseases, 600,000 with diabetes and 400,000 cancer patients, CP receives minimal attention. Frank Huygen told delegates, 70 percent of the patients with chronic pain are treated by their GP, not by a specialist.

The Dutch Council for the Quality of Healthcare, which was established in 2009 to promote high-quality care in the Netherlands, has so far been concentrating on increasing safety, enhancing the patient perspective and stimulating the efficacy of care – with no reference to chronic pain. This prompted the forming of the Workgroup Chronic Pain Council, where members were invited to join based on their specialisation (Anaesthesiology, Neurology, Physiotherapy, Psychology and Rehabilitation), or their long-term involvement with chronic pain (patient, pain nurse), or as a representative of the different stakeholders.

A few months later the working group held a “pressure cooker” session, which was designed to openly discuss statements produced by the participants. Some examples of these statements included: “Chronic pain is a disease in its own right”, “A national guideline on chronic pain could improve diagnosis and treatment”, “Pain medicine will benefit from a patient-oriented approach” and “Profits can be gained with prevention and early recognition”.

The discussion showed that a broadening and deepening of knowledge about pain medicine was clearly necessary. In the short-term this could be achieved by involving non-specialists more. Currently there are only between 300 and 350 pain specialists in the Netherlands. At least 3,000 are needed.

“Currently there are only between 300 and 350 pain specialists in the Netherlands. At least 3,000 are needed.”

The consensus of the working group therefore was to put chronic pain on the agenda of the council for 2012 and for the group to turn itself into a national platform to improve the care of patients with chronic pain. Together with scientific associations and other stakeholders, national guidelines on chronic pain need to be developed with special emphasis on: education and training in pain medicine; stimulating research programmes for chronic pain with special attention to the elderly; and to define the responsibilities of different scientific organisations. “One single solution is not enough anymore”, Huygen said. As a first step, there are plans to hand over a CP report to the chairman of the Permanent Parliamentary Commission.





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Addressing the Societal Impact of Pain in Denmark

Gitte Handberg, Smerte Centre Syd, OUH, Denmark

Presently there are six government and six private pain centres in Denmark. The minimum waiting period is 9 months. At a recent meeting in Copenhagen with some 80 politicians, patients and professionals discussed all points of the EFIC roadmap and the future role of GPs and nurses in primary care. This led to the recommendation of a political hearing and the intention to establish a task force to press for a national plan for action.

Of the one million Danes living with chronic pain, 10 percent are treated by a pain specialist, 10 percent by a GP and a pain specialist and 80 percent just by a GP. The multidisciplinary pain centre where Gitte Handberg works

used to have a waiting list of 2 to 3 years. Due to the capacity of the centre, only a small portion of patients received treatment.

“The solution, which was realised with the help of patients, was simple: share the care between the GP and the pain specialist. A multidisciplinary team now creates a treatment plan two to four weeks after a patient has been referred to the centre.”

The solution, which was realised with the help of patients, was simple: share the care between the GP and the pain specialist. A multidisciplinary team now creates a treatment plan two to four weeks after a patient has been referred to the centre. The aim of the plan is to find the underlying issues relating to a person’s pain, such as family problems, sleep disturbances, existential problems, depression or anxiety. 80 percent of all patients follow the treatment plan as prescribed, while less than 2 percent do not turn up for treatment.



Healthy ageing in relation to chronic pain in the EU

Healthy ageing in relation to chronic pain in the EU

Systematic Literature Review - May 2016



**Dr. Pamela Frances Bell**

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Pain Summit in Northern Ireland

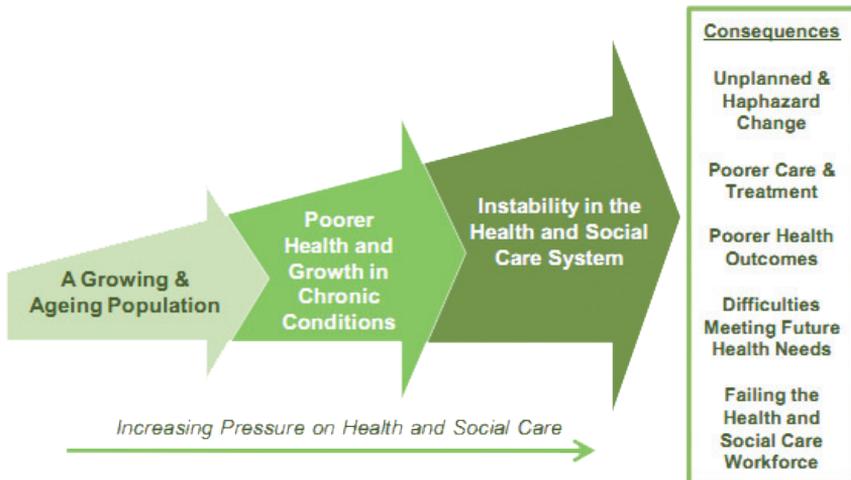
Pamela Bell, Consultant in Anaesthesia and Pain Medicine, Northern Ireland

With a population of 1.75 million, Northern Ireland (NI) cannot boast a particularly healthy economy. 9 percent of their gross domestic product (GDP) comes from agriculture. Heavy industry is almost non-existent and the unemployment rate is 20 percent. Health and Social Care is the major employer.

Since Northern Ireland has the highest prevalence of chronic pain in the UK, pain clinic activity has exploded over the last years: 6,412 new patients were reported in 2011, compared to 2,525 in 2006. Review patients rose from 6,139 to 9,765. Pain management centres are currently doubling their list of pain consultants.

Pain Alliance in Northern Ireland (PANI), the patient-focused support for chronic pain, called for a pain summit in 2012, partly because there had been three major reorganisations of health and social care since 2007, but also to discuss three key publications: Quality 2020 (2010), Care Transfer (2011) and Policy Framework: Living with long-term conditions (2012). In view of the overburdened pain clinics, the main goal of the symposium was to discuss how best to transfer chronic pain patients from clinical provision to community provision. "When it comes to transforming your care", Pamela Bell said, "You first have to identify your stakeholders". And who are they? "The patients, their families and carers, the GPs and their staff, the staff of pain clinics, but also the Patient and Client Council, voluntary sector organisations and local commissioners", she concluded.

Transforming Your Care



WORKSHOP 5

Establishing multi-stakeholder pain platforms in Europe

Bell went on to explain how she got stakeholders to buy into the idea of a pain summit: by touring with a newly-formed reference group; working with the Patient and Client Council to develop a survey about patient satisfaction; meeting with the Commissioner of the HSC Board; and developing a fact sheet and a Road Map for Action. In addition, PANI asked for an informal appearance before the Health Committee of the NI Assembly, lobbied members of the Legislative Assembly and held a Pain Policy Event at Parliament Buildings.

The summit was opened in May 2012 by the Minister for Health, Social Services and Safety. All stakeholders were represented, as were their overarching aims and objectives. There were workshops on education, public health and commissioning, as well as a lot of networking before the meeting was closed by the Chief Medical Officer. According to Bell, there was excellent media coverage in medical and patient journals, as well as regional and national newspapers.

The future looks promising. The Road Map for Action has already been presented at the Pensioners' Parliament by the Age Sector Platform. After writing the summit's report, PANI will give first hand advice to the Minister, the Health Committee and the Chief Medical Officer. The Public Health Agency, commissioners and educators will be informed about the outcomes of the workshops. A Patient Satisfactory Survey is planned in conjunction with the Patient and Client Council and the dialogue with the stakeholders is ongoing.



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The Fourth French National Program of actions for the management of Pain

Michel Lanteri-Minet, Société Française d'Étude et de Traitement de la Douleur (SFETD), France

Presenting the 4th French National Programme of Actions for Pain Management, Michel Lanteri-Minet introduced the audience to the background of an ongoing process aimed at better serving the pain patient. After two previous action plans in 1998 and 2002, the evaluation of a third programme in 2006 also showed flaws. The High Council of Public Health (HCPS) criticised the plan because of too little focus on primary care, an apparently weak tracking of the money flow, poor support for "at risk" groups e.g. mental health, and a lack of cooperation between departments of the French health authorities.

The objective of the 4th French Programme for Pain Management was to increase quality in pain management and differentiate between acute, procedural and chronic pain. The new programme also suggested improving the quality of, and increasing the use of, pain management in primary care, promoting education for both health professionals and pain patients and developing pain management in the mental health field. There was more focus on patients, who should be recognised as pain experts. And finally, clinical and transnational research in pain was to be promoted.

Lanteri-Minet explained how the 4th programme would identify two parallel structures: one for consultations in a primary care setting, the other in pain centres. Each French region is organised under the regional health agency (ARS) with additional local coordination. In practice there are more than 200 structures and the programme receives 60 million Euros per year.

Aligning stakeholder initiatives in the EU member states

Viorica Cursaru, Pain Alliance Europe, Romania

Viorica Cursaru stressed the point that looking at Article 1 of the UN Charta of Human Rights all human beings are born free and equal in dignity and rights. This is reinforced by Article 2 of the EU Charta of Fundamental Rights, according to which all citizens are entitled to be treated equally – a fact endorsed by John Dalli, European Commissioner for Health and Social Policy, who stated in 2010, that “the ultimate objective of the EU is to have patients treated well in their own countries” and again in 2012, with “the time has come for the implementation of EU strategies in the field of health”. Cursaru feels this demand “is absolutely differently applied in Eastern European countries, like Romania”. This is despite the Romanian constitution, according to Article 34, being “obliged to guarantee healthcare”.

In reality, she feels “there is a huge discrepancy between two European systems”. There are the fifteen nations using the Euro (E15) and then there is Eastern Europe (EE). GDP in E15 countries is high (9 to 10), compared to Romania and Bulgaria (3.5 to 6), and this mirrors life expectancy, which averages at 80 to 85 in E15 nations and 65 to 75 in EE countries. Cancer mortality is much higher in Romania, because there is a lack of medication available. The country has the lowest medical expenses in the EU.

Cursaru pleaded for a “collaborative approach”. She said there was a “need for an international system”, which combines patient organisations, doctors, hospitals and scientific researchers. As a Board member of the newly formed Pain Alliance Europe, she believes that “unless the EU participates, nothing will change”.

Best practices should be put into rulings that governments have to respect on a national level. And her strong demand for the EU Commission: Not “wishy-washy” rules or recommendations, but “cross-border healthcare directives”.

Her criticism: “Whenever (parliamentarians) make an announcement there is a lot of ‘may’, but seldom a ‘must’ in it.” Cursaru also felt that if a directive is given, it should be a binding document, as otherwise, “it is a way of shifting responsibility” she said. In conclusion she reminded her audience of the huge discrepancies in pain management and health care between the wealthy EU nations and Eastern Europe.



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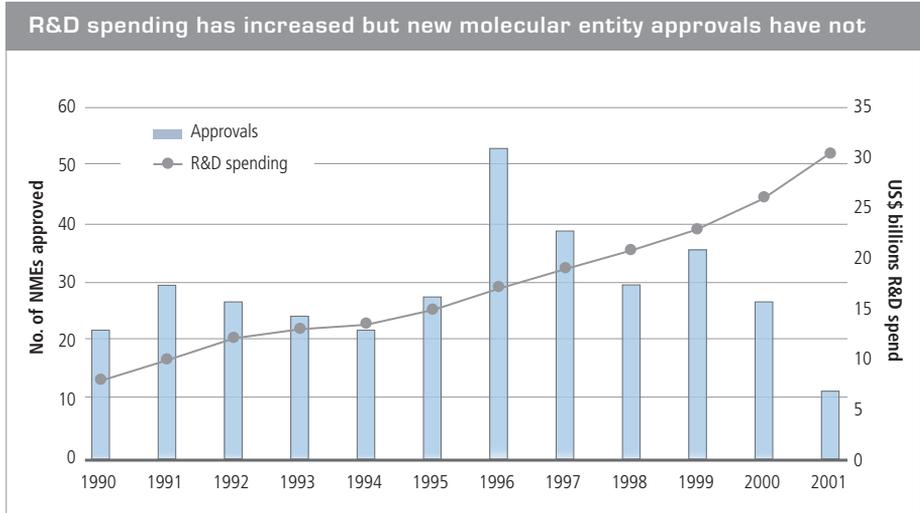
Innovative Agreements for Financing medicines – a new way of involving stakeholders in paying for real health outcomes

Jaime Espin, Andalusian School of Public Health, Spain

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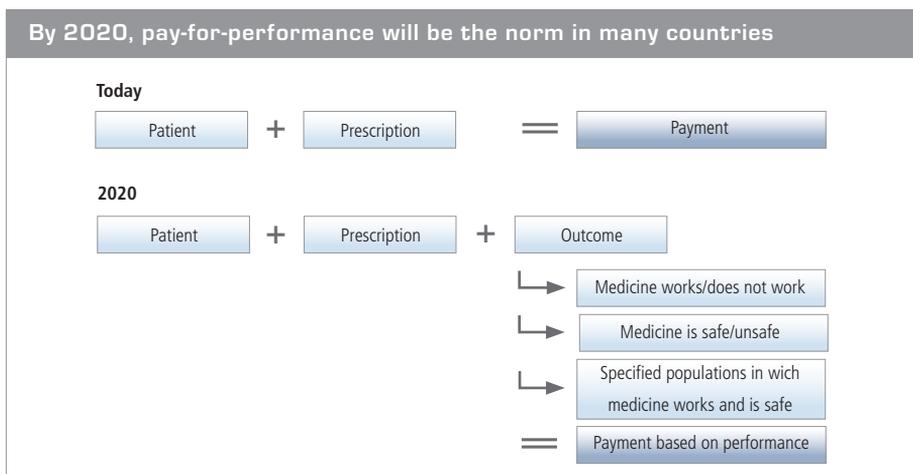
Jaime Espin’s novel suggestion to finance pharmaceutical products and save money at the same time was to “pay for health results”. Taking into account that there are different stakeholder interests, it is difficult to balance the various goals: the government wants to control expenditure while providing access to affordable medicine for the patients; the pharmaceutical industry thinks in terms of innovation, patents and profits; and the European Union wants competitiveness and a free movement of goods. A big financial setback is the approval time for medicines in Europe. In the US and the UK new medicines can be approved by the authorities quite quickly, whereas in Europe approval time is on average 69 days. Furthermore, whereas research and development (R&D) spending has increased, the number of approvals has not.

In the US and the UK new medicines can be approved by the authorities quite quickly, whereas in Europe approval time is on average 69 days. Furthermore, whereas research and development (R&D) spending has increased, the number of approvals has not.



There has to be a new way to finance medicines. A new proposal encourages the payment of a patient's prescription only if the medication works. Its motto is: "No cure, no pay". At the moment, money to pay for medication follows the prescription, but it is predicted that by 2020 a "pay-for-performance" system will be the norm in many countries, depending on whether the medicine works or not.

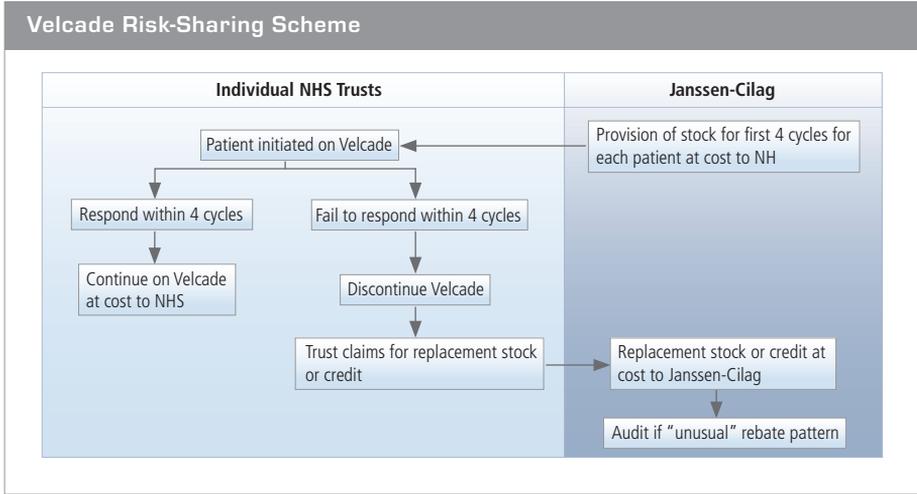
"A new proposal encourages the payment of a patient's prescription only if the medication works. Its motto is: "No cure, no pay"."



The idea is not new. Since 1994 various pharmaceutical companies have offered a money-back guarantee, if the cure has not shown the promised effect. As cancer drugs are particularly expensive, a risk-sharing scheme has already been established in Spain. If a patient who was started on Velcade, a very expensive cancer drug, responds after 4 cycles, the NHS pays. However, if the drug does not show the desired effect after 4 cycles it is suspended and the pharmaceutical company has to carry the costs.

WORKSHOP 5

Establishing multi-stakeholder pain platforms in Europe



Under "traditional contracts", the pharma company has guaranteed revenue per unit sold, independent of the performance of the drug. Under a "risk sharing scheme" with a zero success rate, the organisation would not receive any money. However, if the actual success rate is far above expectations, profit per unit increases substantially for the pharmaceutical company. An "intermediate solution" would be a risk sharing scheme, where the drug manufacturer is guaranteed a small fee per unit sold and a "bonus" for every successful treatment. This way costs could be contained and market growth managed. However, this all depends on finding ways to ensure these new schemes are manageable for the health system.

„The country presentations made clear what to consider when transferring the Road Map for Action to each individual country: it is imperative to install a National Plan against Pain. To accomplish this, a multi-stakeholder platform is needed, consisting of people living with pain, policy makers, parliamentarians and professionals. For this purpose, it is important to identify the right stakeholders: medical doctors of all disciplines, pain nurses, patient initiatives, representatives of the Health Ministry (civil servants, rather than politicians, as once they are voted out the whole process has to start all over again) and the National Health Service. It has also proven helpful to get support from the private sector”.

Presentation: Anna Rosbach, European Conservatives and Reformist Group, European Parliament, Belgium

Working together in politics against pain

The need to measure pain

Chronic pain is a burden to millions of people in Europe. Yet society, governments and health care systems often do not give it the same level of attention as chronic diseases. One reason for this may be that pain in many ways is less obvious to non-sufferers than many other chronic conditions are. But this should not mean it is of less importance. A very important first step towards achieving this is to get chronic pain acknowledged on the same level with chronic diseases in all EU member states. To make these changes, it is necessary to show how important a factor pain can be for those who suffer from it. This can be done by measuring pain.

Economic costs

It is relatively easy to measure at least some of the economic costs of pain in our society. In a simplified way, this can be done by looking at the amount of working days lost due to pain, and how this negatively affects the production output of a country or region. If we want to go deeper than that, we can compare the cost of health care for pain sufferers and the money handed out in benefits and pensions for those who become temporarily or permanently unable to work due to pain. But as anyone dealing with people suffering from pain knows all too well, the impact of pain goes beyond the economy. That is why there is a need for more indicators to measure the consequences of pain.

A “well-being” approach

The “well-being” approach may make measuring pain more complicated, but it also makes the measurement more relevant. This approach offers a systematic path to show how pain might affect the lives of people, directly, as well as indirectly. It also highlights where society needs to intervene. This includes many factors. One in particular should be given additional attention: the importance of work, which is not only good for economic reasons, but also



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for the social contact it offers. Focusing on the economic cost of job-loss following chronic pain only gives part of the picture. By including the well-being perspective, it becomes clear just how important employment is to most people, both economically and socially.

How pain impacts on life

Employment has a direct effect on the way we feel, but also affects several other factors: income level, housing conditions, social contact, the possibility for recreational activities

“A reduction in living standards is likely to affect other family members, as will limitations in social contacts or activities. This means that the effects of pain should not only focus on those suffering directly from it, but also with secondary focus on the family unit.”

and work-life balance. If somebody is struck down by pain to the degree that it affects his or her employment, all the “well-being” factors will be affected as well. And it does not stop there. It can lead to limitations in daily activity, a reduction in the perception of personal health, limitations in social contact and a general feeling of reduced well-being. These indirect effects are often reproduced wholly or partly for the members of the pain-sufferer’s family. A reduction in living standards is likely to affect other family members, as will limitations in social contacts or activities. This means that the effects of pain should not only focus on those suffering directly from it, but also with secondary focus on the family unit.

Finding a solution

Relief for those suffering from pain can come in other forms than “just” pain-reduction, including social help or initiatives. Improving the conditions of pain-sufferers is likely to have a positive effect on more people than “merely” those suffering from the pain. This can help stimulate political interest. It also means that by adopting a well-being approach a different picture evolves when measuring and comparing the outcome of large-scale projects on treating pain. And this is of course why multi-stakeholder pain platforms are vital.

Multi-stakeholder pain platforms

With an issue as complex as pain, it is important to find ways to combine the experience of all those who suffer from it, are treating it, are doing research into it and make decisions

“Politicians must realise that opting for what can seem like the cheapest solution can quickly end up being the most expensive.”

on all levels. Patients need to be organised on a European level in order to create a strong voice. Efforts must join forces and there needs to be an exchange of experiences with prevention and treatment across borders. Politicians must realise that opting for what can seem like the cheapest solution can quickly end up being the most expensive. One clear example is the recent Danish

decision to remove the subsidies for many drugs and put people on cheaper morphine instead. In the end, this will be much more expensive for society, and much harder for the people affected.

The way forward

One of the important roles of multi-stakeholder platforms is to increase the level of knowledge about pain and its consequences. In this way, it is possible to avoid repeating the mistakes of the past, and the present.





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Outlook on future pain management

Presentation: Elisabetta Vaudano, Innovative Medicines Initiative, Belgium

Europain: First assessment of a Public Private Partnership deciphering chronic pain

Public-private partnerships

Europain is a public-private sector partnership, which tries to improve the understanding of and facilitate the development of new treatments for chronic pain. The project is part of a bigger partnership, the Innovative Medicines Initiative (IMI), which is Europe's largest public-private initiative aiming to speed up the development of better and safer medicines for patients. IMI supports collaborative research projects and builds networks of industrial and academic experts in order to boost pharmaceutical innovation in Europe. This partnership has already had some success in developing a treatment for a particular form of leukaemia which had been untreatable and which is now a manageable condition. This approach could also be important in helping to make chronic pain manageable.

Innovative Medicine Initiative (IMI)

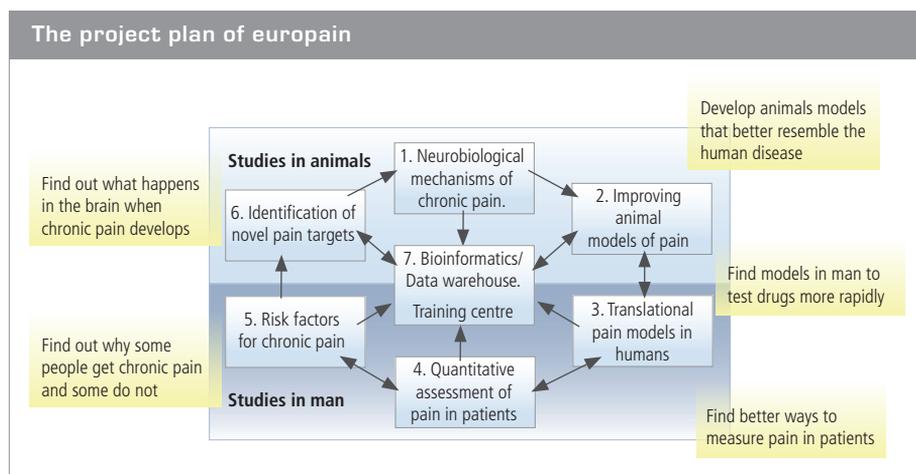
IMI is a partnership between the European Commission and the pharmaceutical industry, working under the umbrella of EFPIA (European Federation of Pharmaceutical Industries and Associations). Both the Commission and the private sector have allocated one billion Euros worth of resources each with the aim of tackling particular bottlenecks in the health sector that impede the development of new and innovative treatment for patients in Europe.

Europain

Europain is one of these initiatives. It is run by a large consortium, which includes the London Pain Consortium, which is also the academic coordinator of the initiative, the German Neuropathic Pain Network and the Danish Pain Research Centre. The main pharmaceutical companies in Europe are equally involved. There is also a coordinator from the pharmaceutical side. Neuroscience Technologies, a small innovative enterprise based in Barcelona is also a contributor to Europain. The project was launched in October 2009 with a budget of 18.5 million Euros and is due to run for a total of sixty months.

Project Plan of Europain

Europain is a very ambitious project. Its aim is to find out why some people suffer from chronic pain and some do not. It also wants to find a better way to measure pain in patients, find human models to test drugs more rapidly, develop animal models that better resemble the human disease and find out what happens in the brain when chronic pain develops.



Not all work can be done on humans. Some has to be done working with animal models. Here it is vital that the work is carried out in the best possible way to get results that can be transferred to human studies, while following strict ethical measures. It is equally important to have an animal model that realistically resembles the human condition. The main problem here is an animal cannot tell you, "I am in pain". To begin to understand what happens in the brain when chronic pain develops, the project has been trying to establish the risk factors that lead to the development of chronic pain. The focus has been on why some people suffer from chronic pain after surgery and some do not. This is of great concern to clinicians because they do not know, when they treat a patient, whether surgery will impact negatively on a patient in future, or not. Firstly, researchers gathered already published material of patients who had different types of surgery to find out if there were predictable factors that could cause post-traumatic pain. They then tried to define some phenotype data that would be useful in subsequent clinical trials for new treatments, because chronic pain patients cannot all be put in one pot. They are different and need more personalised treatment. The results should also try to understand and evaluate the role of different surgical techniques. This programme has already produced 19 publications.

WORKSHOP 5

Establishing multi-stakeholder pain platforms in Europe

Placebo effect

Another issue with developing a new treatment for pain is the placebo effect, the fact that during a clinical trial a lot of people take a sugar pill and still feel much better. It is difficult to know if the actual treatment is effective or not. The project looked at what could influence a patient's perception of a treatment and how expectations and emotional feelings may affect treatment outcomes. First results show the expectation on pain intensity and pain relief influence the pain cessation, so just saying, "I am going to have terrible pain" resulted in patients feeling much worse.

From the public-private partnership perspective, placebo data is being pooled and made available from clinical trials conducted by three major pharmaceutical companies. This pulling together of data will benefit research greatly, because often only small amounts of data are available, which makes it difficult to get conclusive results. This data will be used to look at the effects of patient characteristics. It should also help find answers to different design and operational questions to identify risk factors for large placebo responses in future trials.

Quantitative Sensory testing

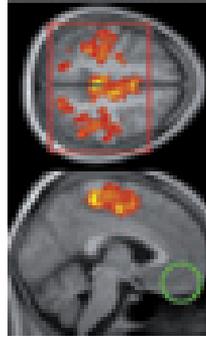
Clinical trials need an end point that can measure chronic pain patients. A quantitative sensory testing model with a multilingual questionnaire has been developed to allow as many people from as many countries as possible to take part in the trials. The consortium is currently running the first trial to try to establish a predictor response. A drug that is already on the market is being used because the purpose is not to test the drug, but to test the methodology. Here again, the trial is being run by academics in public hospitals, but with in-kind contributions from pharmaceutical companies that are normally in competition with each other. Patient recruitment is going well for this study.

Brain activity

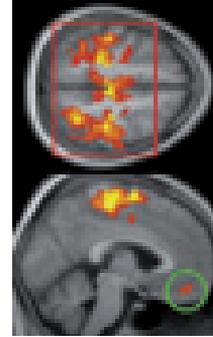
The project also demonstrates how the brain reacts to pain. Using MRI imaging it is possible to show how the brain's network functions. In particular, with resting brain activity (RSN), a MRI scan can visualize functional changes in neural networks in chronic pain patients. The research discovered chronic pain causes a functional disintegration of RSN. Even in healthy participants, ongoing activity between pain processing brain regions in the resting state changed with exposure to pain. Using a healthy volunteer the study showed the activity of the brain after the participant had experienced pain during one particular day. In the next phase of the study, measurements of the brain were taken 11 days later, after the same volunteer had endured similar levels of pain daily. The pain levels should reflect what an actual pain sufferer might experience. The results showed activation in a new part of the brain. This indicates chronic pain does change the way the brain works.

Effects of chronic pain on the brain

Repeated pain induces adaptations of intrinsic brain activity to reflect past and predict future pain



CHRONIC PAIN
CHANGES THE
WAY THE
BRAIN WORKS



Working across species

An experimental model is necessary to distinguish between “evoked pain”, which might be a pin prick, a burn or a scratch, and “ongoing, spontaneous pain” which is more relevant to chronic pain. A strategy is being developed to create translational pain models in humans. Analysis data of human experimental pain studies are being gathered to get a more consistent picture and new models are being introduced e.g. the menthol model, freeze model and sleep deprivation model. There is also important translational analysis being carried out across species, like rodents, where the search is for biomarkers, or biological states, that are recognised in both human and animal.

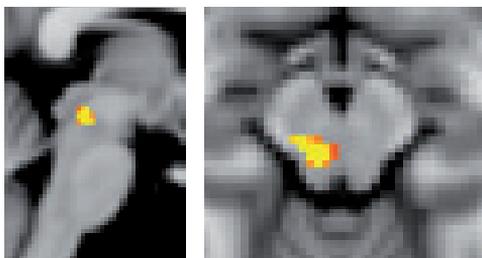
The research team is also looking at new labelling, e.g. the Arterial Spin Labelling (ASL) technique of imaging. This work is carried out at Oxford University in England. Healthy subjects are exposed to topical capsaicin, a substance that gives chilli peppers their characteristic. As well as experiencing an acute sensation of burning, participants developed an area of secondary hyperalgesia. The imaging technique allowed researchers to see how this secondary area of hyperalgesia corresponded with brain activity. Further changes occurred following treatment, which included gabapentin, ibuprofen and a placebo. This indicates again the possibility to develop an end point that can be used to quantify exactly what is going on in the brain and the changes that can occur with treatment.

WORKSHOP 5

Establishing multi-stakeholder pain platforms in Europe

Neuroimaging - ASL in healthy volunteers

- A study (Oxford) in healthy subjects exposed to topical capsaicin shows increased BOLD activity in the brain stem in response to punctate stimuli in the area of secondary hyperalgesia.
- Gabapentin, ibuprofen and a placebo were used to validate this model.



Models and biomarkers

The sleep deprivation model is useful because it is well known chronic pain disturbs sleep patterns and can intensify the level of pain. This study showed how volunteers became more sensitive to pain the longer they were deprived of sleep. Most importantly, the same reaction occurred with rodents, which indicated clinical studies could be carried out first in animals, then healthy volunteers and finally pain patients to give a more accurate picture.

It is difficult to measure ongoing spontaneous pain in animals, which is much more relevant to the chronic pain patient. However, researchers have developed a well-designed model (Burrowing model), where the burrowing performance of rodents, which is a natural behaviour for them, was impaired when they were in pain. This model demonstrated again the strength of collaboration between the public and private sectors, as it was developed and validated both by an academic partner (Imperial College London) and a pharmaceutical company (Pfizer). It has since been successfully implemented by a number of pharmaceutical companies but also academic laboratories, for example, at Aarhus University.

Microneurography has been developed by Neuroscience Technologies in Barcelona and is again an example of a cross-species (animal and human) technique and allows researchers to measure activity in the neuron when there is spontaneous pain due to nerve injury.

Future benefits

This is just a snapshot of what can be produced when people from the public and private sectors work together with the same goal in mind. These preliminary results, which reflect the work carried out in the past two years, already indicate how Europe could benefit from this partnership. A better understanding of how pain affects the patient could help reduce the economic burden that pain places on healthcare systems and EFPIA and biotech businesses could use this knowledge to help find new drug treatments, as there has been nothing new in this field in the last twenty years and the discovery of new and effective drugs could contribute to economic growth in the long-term.



WORKSHOP 6

Outlook on future pain management



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Outlook on future pain management

Reporters: Ruth Zaslansky & Fred-Holger Ludwig, Germany

Introduction

This workshop gave participants the opportunity to discuss future trends in policy making for pain care. Different stakeholder representatives shared their views on the near- and long-term future for pain policy.



How HTAs can improve pain care in the future

Finn Børlum Kristensen, DACEHTA, EUnetHTA, Denmark

Finn Børlum Kristensen began his talk by explaining how Health Technology Assessment (HTA) is relevant to the field of pain. In chronic pain, and even pain in general, there are many therapeutic options available to patients, not only pharmacological, but also psychotherapy or psychology. Therefore, the aim of HTA is to find out which interventions are safe, effective, patient-focused and cost-effective. HTA helps decision makers assess which treatments to choose from and how to do this in a rational way. It is a field that studies the medical, social, ethical, and economic implications of developing, diffusing and using technology in health care.

HTA is carried out by a multidisciplinary team, which includes healthcare researchers, but also epidemiologists, statisticians, economists and other disciplines. The field is not so much about making decisions, but providing information for decision-makers.

The people associated with the current network are working to establish a permanent network within Europe, under the name of 'EUnetHTA'. The partners associated with establishing the network have joined at different stages, starting from 2005. The network now includes participants from nearly all EU member states, key institutions that deal with HTA and key regional agencies and not-for-profit organisations that produce or contribute to HTA within Europe. The network is led from Denmark.

The stakeholders involved in the network include a Stakeholder Forum, consisting of patients, industry, payers and providers, and an Executive Advisory Group, whose role is to plan the research activities of the network. The Stakeholder Forum works closely with the Executive Committee.



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Rheumatoid Arthritis: A vision of the present and look into the future. Results of multi-disciplinary qualitative study

Joana Gabriele Muñiz, Josep Laporte Foundation, Barcelona, Spain

Joana Gabriele Muñiz started her talk by saying that 12 years ago the European Board of Rheumatology decided to place special emphasis on addressing all types of arthritic pain, including rheumatoid arthritis (RA), using a multi-disciplinary model focusing on the needs of the individual. According to the WHO, care is 'patient-centred' when it addresses seven themes, which include: having treatment that is equitable; engaging all stakeholders; empowering the patient and using evidence-based research.

Rheumatoid arthritis is a major burden on health and social care within Europe with as many as 30% of adults affected at any one time by it. In 1988, the Spanish Society of Rheumatology developed a clinical practice guideline for management of rheumatoid arthritis (GUIPCAR) with the objective of reducing variability in care. This was followed by a study to assess the epidemiology and impact of rheumatoid arthritis in Spain. The main findings showed that the prevalence of RA in the Spanish population over the age of 20 years was 0.5%; it was highest in women between the ages of 40 to 60 years of age; RA was under-diagnosed in the general population; and treatments with demonstrated efficacy in RA were not administered systematically to patients. Lastly, RA significantly affected the quality of life of patients and their relatives.

A follow-up study assessed the discrepancies between the published clinical practice guidelines of the Spanish Society of Rheumatology and the experiences of patients, their relatives and healthcare professionals. This study found evidence of considerable delay in diagnosis and treatment of RA, sometimes exceeding one year or more. This was in contrast to GUIPCAR recommendations and standards. The authors listed 6 areas for intervention in future. These included: providing information and knowledge; carrying out early diagnosis and treatment; providing multidisciplinary care; 'patient-centred care'; coordinating the care; and providing better follow up of care.

Quantitative and qualitative analysis of the use of the opiates and satisfaction of the recruitment standards of palliative care



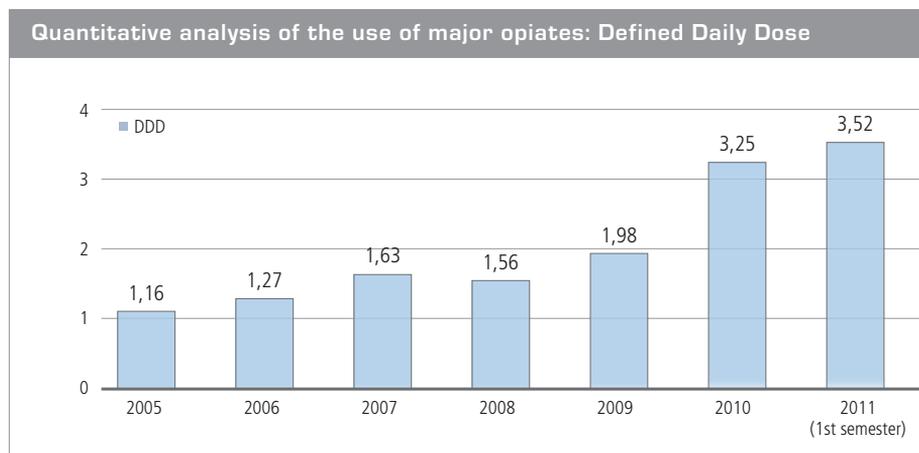
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Marco Luciani, ULSS7 de Veneto, Italy

Marco Luciani works as a physician within a Palliative Care Team in the north-east of Italy. A hospice is due to open in autumn 2012. Until then, the care team will continue offering palliative care at home.

The Palliative Care Team is multidisciplinary and comprises of a general practitioner, a palliative care physician, nurses and a psychologist. The team's tasks are to provide the patient and his/her family, on the one hand, with palliative care and on the other, the option to live the last phases of the patient's life in a safe and comfortable environment. The approach is based on the Italian law from 2010, no 38 which, amongst other issues, aims to ensure administration of palliative care to terminally ill patients.

In his talk, Luciani presented data that the team collected during home visits between 2005 and 2011. They addressed two issues: consumption of opioids and standards regarding recruitment of patients to Palliative Care.



WORKSHOP 6

Outlook on future pain management

The team assessed various aspects of opioid administration including types of opioid, methods of administration and ratio between short- and long-acting medications. They also assessed patient satisfaction. In 2010, 83% of patients were satisfied with the treatment they had received, 87% felt they had received “quick pain relief” and 96% thought they were free of pain and were “well” throughout the treatment period. An increase was noted of the number of patients assessed by the Palliative Care Team – from 50 at the end of 2006, to 353 in 2011. This covered 61% of needs. Luciani attributed the increase in patient recruitment to collaboration between the members of the Palliative Care team.

Goals for the Palliative Care Unit in the new hospice include treating not only cancer patients, but all terminally ill patients. Furthermore, new treatment options will be available once the hospice opens in the autumn of 2012.



Patient-reported outcome in analgesic treatments: switching assessment toward the patient, for more realistic goals

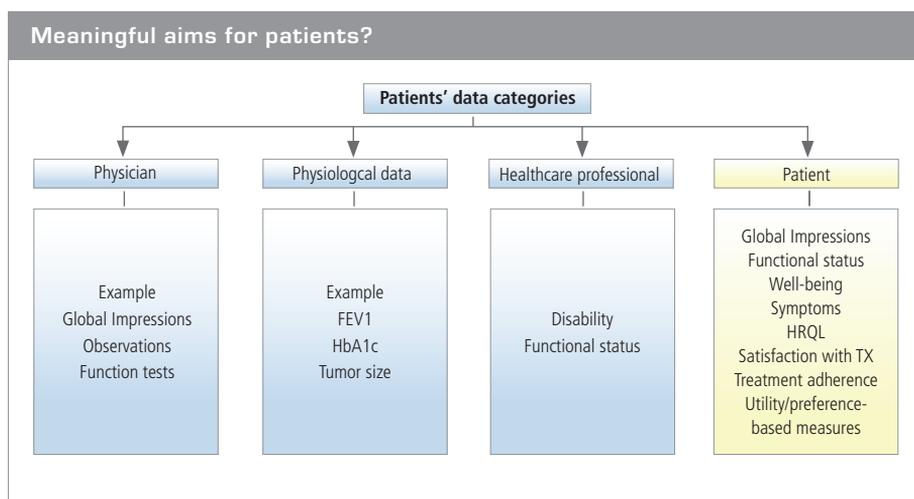


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Serge Perrot, Cercle d'étude de la douleur en Rhumatologie, France

Serge Perrot is a rheumatologist and pain specialist at the Hotel Dieu University Hospital in Paris. The aim of his talk was to discuss the importance of patient involvement in the assessment and management of pain, using Patient Reported Outcomes (PROs).

Pain is assessed for the sake of establishing a diagnosis, but also as part of the process to decide on the aims of management. Chronic pain is assessed using multiple levels of assessment; going beyond the visual analogue scale (VAS), which assesses only one dimension: the intensity of pain. Other levels of assessment include the degree of functional impairment, psychological impact, the degree of handicap, quality of life and economic and social costs. Physicians collect a great deal of data when they evaluate patients, but most of it is based on the physician's and other health-care provider's point of view. There is a need to switch from physician-centred assessment to a patient-centred assessment.



WORKSHOP 6

Outlook on future pain management

The concept of PROs has now been described in several publications. They represent the patient's view point about a health condition and its treatment. This leads to a question of how to go about setting realistic goals using PROs and how to use the concept, "It's good to be better, but it's better to be good, as long and as fast as possible", Perrot said. Several studies demonstrated a discrepancy between what clinicians defined as "clinically meaningful" change and what patients regarded as meaningful.

PROs are now being integrated into national healthcare systems. For example, Britain's National Health Service (NHS) is implementing PROs in routine practice. In research, much emphasis is still placed on physician-based ratings, but PROs should also be included. To conclude, it is important to integrate PROs into various spheres of patient assessment, in particular, in the field of pain, which is subjective.



Registries as a base for pan-European health services research in the field of pain

Winfried Meissner, PAIN OUT, Germany

Winfried Meissner began his talk by describing that a registry is a system that uses observational methods to evaluate a population defined by a particular disease or condition and that information derived from the registry can serve scientists, clinicians or policy-makers. Data from registries mirror daily practice, as opposed to Randomized Controlled Studies (RCTs) which assess a highly select population.

PAIN OUT is a registry following outcomes related to pain after surgery. The project was funded by the FP7 programme of the European Union and is being carried out in clinical centres within Europe, but also internationally, in the US, Malaysia and Africa. Patients fill in a validated questionnaire, available in 18 languages, assessing Patient Reported Outcomes (PRO) such as: intensity of pain, side effects and the care related to pain. Summarised data is then fed back to clinicians and used to improve the quality of care they provide to their patients. The data can also be used by researchers. Topics that can be assessed include epidemiology of pain (e.g. incidence), areas of under- or overtreatment, and to assess the effectiveness of interventions.

Meissner gave examples of studies which have been carried out. The first looked into variation of care, assessing whether there was a discrepancy between guidelines and how they were put into practice by clinicians. Only 20% of patients received treatment after a common procedure, such as laparoscopic cholecystectomy, that was based on five recommended interventions. The second study looked at long-term outcomes, related to surgery. This was carried out by providing patients who had already assessed their outcomes on their first day after surgery, with additional questionnaires at 6 and 12 months after surgery. Lastly, as the registry is international, the data can be used to assess cultural differences between patients. One example of these differences is in the use of non-pharmacological methods for alleviating pain after surgery.

In conclusion, PAIN OUT has created an international platform for research in pain. The data is based on PROs. Research in the field of pain can be advanced by complimenting RTCs with information derived from registries.



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“PAIN OUT has created an international platform for research in pain. The data is based on PROs. Research in the field of pain can be advanced by complimenting RTCs with information derived from registries.”



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Quality registries in Sweden: The national agreement between the government and SALAR

Lars Backlund, Swedish Association of Local Authorities and Regions (SALAR), Sweden

Lars Backlund opened his talk explaining that in Sweden there are 73 National Quality Registries (+ 27 registry candidates) and 7 Competence Centres (QRs) subsidised by the state. The registries were set up for research purposes, to improve standards and to use as a tool to follow up studies and compare results. Medical professionals started the initial programme in 1975. The focus was on knee surgery and the aim was to receive individual data concerning problems with patients, operations and results

after treatment.

An Executive Committee administered by SALAR monitors the work annually and approves any financial support. The vision is for the National Quality Registries (NQRs) to be fully integrated into the Swedish Health Care System and used for continuous learning and improvement, as well as for the management of research and knowledge to attain the best treatment.

As positive examples, Backlund mentioned paediatric oncology, the National Cataract Register and the Swedish Hip Arthroplastic Registry.

SALAR has successfully secured funding of 320 million SEK each year between 2012 and 2016. 70% will come from government, the rest will be paid by local authorities. The pharmaceutical industry is not part of the registry budget. However, there is a separate agreement based on the partnership between the pharmaceutical industry and SALAR. The project mainly focuses on the following areas: general medicine, psychiatry, dentistry and social services.

The funding should help SALAR achieve some of its general goals, which include: a faster development of Competence Centres (QRs), better integration and usage of information technology and informatics, better integration between the electronic patient's card and QR (avoiding double registration); and a transparent routine in relation to patient integrity.

Indirect Costs of Chronic Pain in Portugal

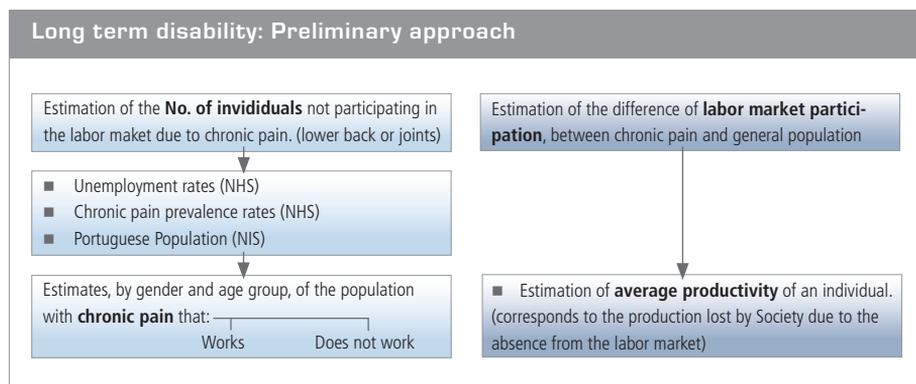
Miguel Gouveia and Margarida Augusto, Center of Medicine-based Evidence (CEMBE), Lisbon, Portugal



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In Portugal, chronic pain is a central political issue, which is implemented within the “National Programme for Pain Control”. In 2002, the “National Health Observatory” estimated that 74% of the population suffered from pain. After this estimation, a survey of more than 5,000 citizens revealed that 34% of the population suffered from chronic pain.

The reduction, or even loss, of work productivity, due to morbidity and mortality, means indirect costs for chronic pain are high, as absenteeism is often related to health problems. Gouveia and Augusto are convinced the indirect costs of back and joint pain due to absenteeism can be reduced by preventing pain becoming chronic. Surveys have revealed that 11,966 men and almost 20,000 women have had to give up their jobs because of chronic pain. (Portugal, 2008) The indirect costs for back and joint pain add up to approximately 73,985 million Euros, which is an average loss of 160.59 Euros per worker (0.46% of Portugal’s GDP).



Gouveia and Augusto concluded that a more effective use of resources and a more intensive effort to prevent or reduce chronic pain could positively influence the health and welfare of the Portuguese population.



Dr. Daniele Battelli
San Marino
Associazione Sammarinese
per lo Studio del Dolore

San Marino Analgesic Observatory: results and perspectives

Daniele Battelli, Università degli Studi di Modena e Reggio Emilia, San Marino

Daniele Battelli is a physician working in the Republic of San Marino, where he and his colleagues have been carrying out analysis of prescription practices of GPs related to analgesics since 2007.

In San Marino, proton pump inhibitors (PPIs), non-steroidal anti-inflammatory drugs (NSAIDs) and opioids are prescribed without cost to patients. Information about distribution is centralised.

The group analysed data relating to 3 variables: annual number of prescriptions for PPIs, NSAIDs and opioids; gastro-intestinal findings associated with NSAIDs in patients who underwent at least one endoscopy; and creatinine levels of these patients. The findings were analysed in relation to the country's adult population. The authors used the "defined daily dose" (DDD) as the unit of assessment.

The results showed that NSAIDs topped the list of the ten most prescribed medications. Battelli referred to them as "organ-damaging drugs". Opioids were the least prescribed. This trend was similar for over 65-year-olds. NSAIDs were still the most frequently prescribed, although there was an increase in the use of tramadol. Transdermal opioids, buprenorphine and fentanyl were prescribed infrequently. Morphine was prescribed least often.

Data from the endoscopy assessments revealed that although a third of the study group was being given PPIs, 59 events were linked to the use of NSAIDs in patients with positive endoscopy findings, and 14 ulcer bleedings were detected. Sixty three percent of patients were treated with an anti-coagulant or treated chronically with an analgesic.

Furthermore, in patients with positive endoscopic findings, fewer PPIs and more NSAIDs had been prescribed, compared to the general population. Similarly, patients with high levels of creatinine were also prescribed more NSAIDs. Battelli said these findings indicated that the treatment of these patients was not optimal and that physicians should be more attentive to renal damage associated with NSAID usage.

As a result of these findings, the group initiated an education programme for GPs and patients. It is continuing to monitor and analyse prescription practices.





Advancing pain management in Swedish primary care through quality registry – a regional collaboration project in Sweden

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Björn Gerdle and Britt-Marie Stalnacke, Linköping University, Sweden

This regional project was established with the aim of bringing multimodal rehabilitation programmes to Sweden. Already in 1999, Gerdle and a fellow researcher were explaining the need for chronic problems to be managed using a multi-disciplinary approach with different levels of intensity, depending on a patient’s particular situation. Some synchronized activities should last several weeks, often as a team activity. This was the research team’s definition of “multimodal rehabilitation”. (Gerdle & Elert, 1999)



Stefano Caccioli
 Perugia University, Italy

Eija Kalso
 President IASP

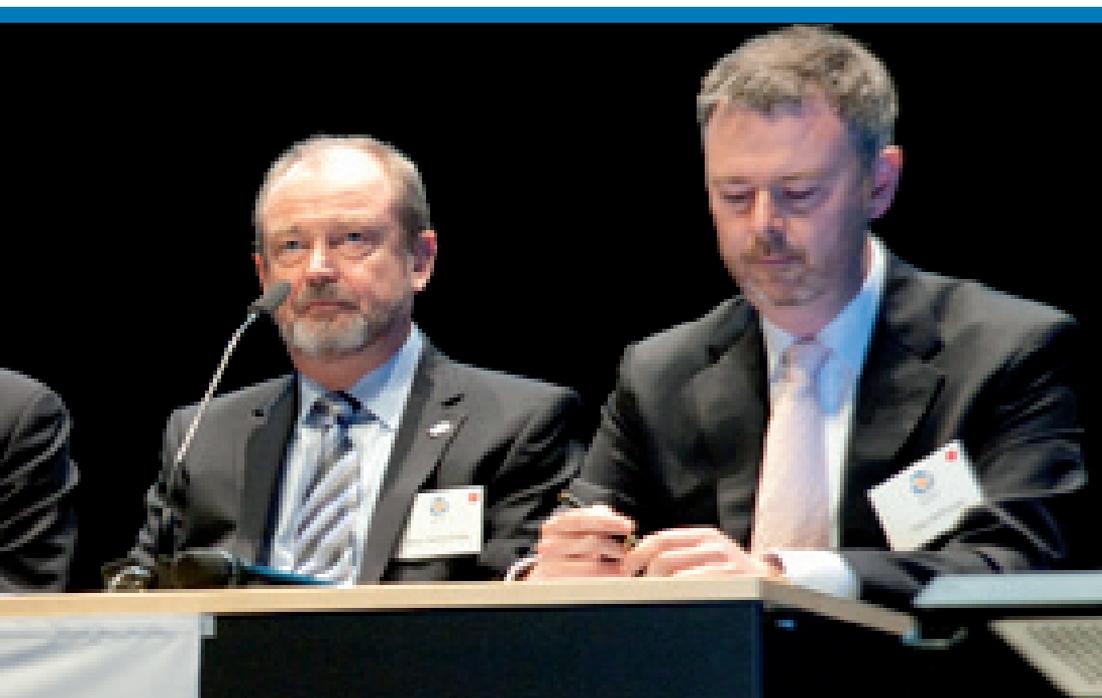
Joop van Griensven
 President Pain Alliance Europe

This form of rehabilitation is a complex intervention that affects the entire human being, and a variety of topics, such as: symptoms; coping with pain; psyche; disability; participation and health, including; pharmacologic operations, biochemical processes and the intensity of pain, need to be considered.

Gerdle and Stalnacke indicated that multimodal rehabilitation is more effective than less intensive operations. (SBU, 2006 & 2010) Partly due to this, Sweden now guarantees a national rehabilitation programme for primary care users in all county councils across Sweden.

However, a few problems are still evident. So far there are no unified strategies across Sweden to identify patients who need multimodal rehabilitation – neither in general practice, nor in specialist fields. Easy and systematic routines to evaluate the results in general practice are also still missing.

The aim is to carry out a full evaluation of the multimodal programme in primary care, and to develop an instrument to show the most appropriate provision of care for each individual patient.



Hans Georg Kress
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SQRP – Swedish Quality Registry for Pain Rehabilitation

Marcelo Rivano Fischer, Swedish Pain Society, Sweden

The aim of the Swedish Quality Registry for Pain Rehabilitation is to: support members in their quality improvement activities; offer a service by developing evidence-based methods; establish adequate comparisons with other member groups to improve the national standards of pain rehabilitation.

In 2010, 842 out of 1,272 patients (or nearly 65%), who had received rehabilitation the previous year, took part in a “follow-up” study. Out of these 842 patients, 189 (23%) handed in incomplete answers in relation to approach, satisfaction and continuation. These people were excluded from the analysis.

The study showed that in 2010, patients had to wait an estimated 68 days for a pain team screening. 14 out of 20 facilities made contact with a patient within the statutory time frame of less than 90 days. Only 7 facilities made contact within 60 days. The estimated waiting period for a pain rehabilitation programme was 55 days in 2010. 15 out of 20 facilities succeeded in implementing the rehabilitation programme within the statutory timeframe (less than 90 days) – 8 facilities managed the process within 60 days.

Rivano Fischer concluded that patients with persistent pain have worse health experiences than, for example, people with spinal cord damage. They perceived their pain as “invisible”, and wondered if they were deluding themselves, and that it was just “pain in the head”. Correspondingly, experiences with administrative bodies were described as frustrating and negative.

Fischer considers further research as a very important aspect to improve the recognition of pain and pain patients. In his opinion adequate care and the implementation of registries could also help improve strategies.

Professional identity and network relationships in pain management

Maria Giulia Marini, Fondazione ISTUD, Italy

Maria Giulia Marini works at the ISTUD Foundation, an independent business school in Italy associated with executive education and management research. Due to the introduction of Law 38 in 2010, palliative care and pain management have been prioritised in the Italian healthcare system and palliative care networks are to be created in each region of Italy. The Minister of Health has also defined minimum requirements for staffing levels, skills and experience in palliative care and pain amongst healthcare providers.

Marini began her presentation by describing the study she is conducting using the methodology of “climate analysis”, which is carried out within organisations or teams to evaluate issues, such as: the needs of workers; dynamics of communication; strong and weak points in the organisation; and quality of leadership.

The study tools include “quantitative variables”, such as demographic information, a job description, team organisation and workload, relationships with patients, personal motivation and expectations and an evaluation of the quality of each person’s professional life. The “qualitative analysis” includes semi-structured “fairy tales” to assess the choice of each person’s profession. The rationale behind this method is that humans are storytellers by nature and stories require attention and promote reactions. Stories help to better understand the experience, values and needs of healthcare professionals. Furthermore, the stories can provide information as to how the services providing care for pain are organised.



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WORKSHOP 6

Outlook on future pain management

The anticipated outcomes of the study are to create a national map of the active centres, which deal with pain therapy, a preliminary assessment of “quality of life” and the needs of healthcare professionals, and a starting point for creating an action plan to provide support for healthcare professionals and their organisations. Marini made clear this would all be carried out with limited financial resources.

The 10-month study is scheduled to end in October 2012. Early findings revealed that healthcare professionals from all regions of Italy had been interviewed. 96% had been anaesthetists, 2% were nurses and 2% physiotherapists. The majority of those who participated were male. Their stories indicated commitment, in terms of existential values against pain and suffering. However, there was some dissatisfaction about the scarcity of resources to implement Law 38.



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Andrea Warpakowski
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Alliance Europe

ALLIANCE OF PEOPLE WITH CHRONIC PAIN

Mission

Improve the quality of life of people with chronic pain in Europe.

Aims of PAE

- have chronic pain recognised as a disease in its own rights.
- a greater awareness of chronic pain.
- a European policy on chronic pain.
- of chronic pain on all society.



The Societal Impact of Pain “A Road Map for Action”

One of the key results from the 2nd European symposium on the “Societal Impact of Pain” (SIP 2011) in the European Parliament in Brussels/Belgium, published on 4 May 2011 (www.sip-platform.eu).

In 2001, the European Federation of the International Association for the Study of Pain Chapters (EFIC) published its Declaration on Pain which called on national governments and the EU Institutions to increase the level of awareness of the societal impact of pain. Ten years on from the EFIC Declaration on Pain, national and EU policy action has been very limited. At the same time, basic and clinical science have demonstrated the feasibility of pathways out of pain for many types of acute and chronic pain, but health care systems currently do not guarantee general access to these.

According to the 2007 Eurobarometer survey on “Health in the European Union”¹, almost one third of respondents experience musculoskeletal pain which affects their day-to-day life. The burden of suffering that pain imposes on individuals and the enormous costs that society has to bear not only by healthcare systems but also the social, economic and employment sectors only illustrate the urgency for European governments and the EU Institutions to act and to put, as a priority, the societal impact of pain on their policy agenda.

We call on European governments and the EU Institutions to:

1. Acknowledge that pain is an important factor limiting the quality of life and should be put on the top of the priority list of the national health care system.
2. Activate patients, their family, relatives and care-givers through the availability of information and access to pain diagnosis and management.
3. Raise awareness of the medical, financial and social impact that pain and its management has on the patients, their family, care-givers, employers, and the healthcare system.
4. Raise awareness of the importance of prevention, diagnosis and management of pain amongst all healthcare professionals, notably through further education.
5. Strengthen pain research (basic science, clinical, epidemiological) as a priority in EU framework programme and in equivalent research road maps at national and EU level, addressing the societal impact of pain and the burden of chronic pain on the health, social, and employment sectors.
6. Establish an EU platform for the exchange, comparison and benchmarking of best practices between member states on pain management and its impact on society.
7. Use the EU platform to monitor trends in pain management, services, and outcomes and provide guidelines to harmonize effective levels of pain management to improve the quality of life of European Citizens.

¹ Eurobarometer survey on “Health in the European Union”, Special Eurobarometer 272e, September 2007 http://ec.europa.eu/health/ph_publication/eb_health_en.pdf



SIP

Endorsing Organisations

The scientific aims of the SIP 2012 symposium under the responsibility of the European Federation of IASP[®] chapters (EFIC[®]) have been endorsed by the following large number of pain advocacy and scientific organisations:

The Societal Impact of Pain (SIP) 2012 symposium took place under the high patronage of the Italian Presidency of the Council of Ministers.



The Societal Impact of Pain (SIP) 2012 symposium took place under the high patronage of the Italian Ministry of Health.



1.  **Academia de Ciencias Médicas de Bilbao**
www.acmbilbao.org
2.  **Action on Pain**
www.action-on-pain.co.uk
3.  **Andalusian Society of Palliative Care**
www.paliativosandalucia.com
4.  **Arthritis and Musculoskeletal Alliance (ARMA)**
www.arma.uk.net
5.  **Asociación Andaluza del Dolor**
www.asociacionandaluzadeldolor.es
6.  **Asociación española de enfermería de anestesia-reanimación y terapia del dolor (aseedar-td)**
www.aseedar-td.org
7.  **Asociación Extremeña de Fibromialgia**
<http://afibroex.com/>
8.  **Association of Patients with fibromyalgia and chronic fatigue syndrome of the Community of Madrid (AFINSYFACRO)**
<http://www.afinsyfacro.es/>
9.  **Association française de la cystite interstitielle (AFCI)**
<http://asso.orpha.net/AFCI/cgi-bin/>
10.  **Association Francophone pour Vaincre les Douleurs (AFVD)**
www.association-afvd.com

Azorian Association of Chronic Pain Patients (ADDCA)



11.

Associação Portuguesa de Cuidados Paliativos – Núcleo Regional dos Açores (Portuguese Association of Palliative Care – Azorian Regional Nucleus)



12.

www.apcp.com.pt

Associazione Sammarinese per lo Studio del Dolore



13.

www.assd-rsm.org

Association for Pain Therapy Bosnia and Herzegovina



14.

www.apth-bh.ba

BackCare, the charity for healthier backs



15.

www.backcare.org.uk

Belgian Back Society (BBS)



16.

www.belgianbacksociety.be

Belgian Pain Society (BPS)



17.

www.belgianpainsociety.org

Berufsverband der Ärzte und Psychologischen Psychotherapeuten in der Schmerz- und Palliativmedizin in Deutschland e.V. (BVSD)



18.

www.bv-schmerz.de

Bildungswerk Aachen: Servicestelle Hospizarbeit für die Städte Region Aachen



19.

www.servicestelle-hospizarbeit.de

British Pain Society



20.

www.britishpainsociety.org

The British Pain Society

21.



Chronic Pain Ireland
www.chronicpain.ie

22.



Cittadinanzattiva
www.cittadinanzattiva.it

23.



Collectif DOLOPLUS
(Pain Assessment in non communicating elderly patients)
<http://www.doloplus.com/>

24.



Consellería de Sanidade de Galicia
www.sergas.es

25.



Croatian Society for Pain Treatment
www.hdlb.org

26.



Czech Pain Society
(Společnost pro studium a léčbu bolesti - SPLB)
www.pain.cz

27.



Danish Association for Chronic Pain Patients
(FAKS) Foreningen Af Kroniske Smertepatienter
<http://www.faks.dk>

28.



Deutsche Schmerzgesellschaft e.V. (German Pain Society)
www.dgss.org

29.



Deutsche Schmerzliga e.V.
www.schmerzliga.de

30.



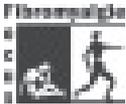
Deutsche Gesellschaft für Anästhesiologie und Intensivmedizin (DGAI)
www.dgai.de

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|---|--|------------|
| <p>Deutsche Gesellschaft für Schmerztherapie e.V. (DGS)
German pain association - Société Allemande de la Douleur
www.dgschmerztherapie.de</p> |  | <p>31.</p> |
| <p>Deutsche PalliativStiftung
www.PalliativStiftung.de</p> |  | <p>32.</p> |
| <p>Deutsche Seniorenliga e.V.
www.deutsche-seniorenliga.de</p> |  | <p>33.</p> |
| <p>Deutscher Orthopäden-Verband e.V. (DOV)
www.dov-online.de, www.ihrarzt.de</p> |  | <p>34.</p> |
| <p>Deutsche Wachkoma Gesellschaft
www.schaedel-hirnpatienten.de</p> |  | <p>35.</p> |
| <p>Douleurs Sans Frontières (Pains without Borders)
www.douleur.org</p> |  | <p>36.</p> |
| <p>Dutch Pain Society
www.dutchpainsociety.nl</p> |  | <p>37.</p> |
| <p>Endometriosis Association of Ireland
www.endo.ie</p> |  | <p>38.</p> |
| <p>EURAG Österreich
www.eurag.at</p> |  | <p>39.</p> |
| <p>EUMUSC.net
www.eumusc.net</p> |  | <p>40.</p> |

41.  **Europacolón Portugal (Association for the Fight Against the Colorectal Cancer)**
www.europacolón.pt
42.  **European Cancer Patient Coalition (ECPC)**
www.ecpc-online.org
43.  **European Federation IASP Chapters (EFIC)**
www.efic.org
44.  **European Federation of National Associations of Orthopaedics and Traumatology (EFORT)**
www.efort.org
45.  **European Federation of Neurological Associations (EFNA)**
www.efna.net
46.  **European Headache Alliance**
www.e-h-a.eu
47.  **European Network of Fibromyalgia Associations (ENFA)**
www.enfa-europe.eu
48.  **European Platform for Patients' Organisations, Science and Industry (EPPOSI)**
www.epposi.org
49.  **European Society for Regional Anaesthesia & Pain Therapy (ESRA)**
www.esraeurope.org
50.  **European Society of Anaesthesiology (ESA)**
www.euroanaesthesia.org

The scientific aims of the SIP 2012 symposium under the responsibility of the European Federation of IASP® chapters have been endorsed by the following large number of pain advocacy and scientific organisations:

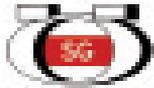
Societal Impact of Pain (SIP) 2012
Copenhagen, Denmark
29 - 31 May, 2012

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| Federación de Asociaciones de Enfermería Comunitaria y Atención Primaria (FAECAP)
www.faecap.com |  | 51. |
| Federdolore-Società Italiana dei Clinici del Dolore
www.federdolore.it |  | 52. |
| Fibromyalgie en Samenleving (F.E.S.)
De nationale Vereniging voor Fibromyalgiepatienten
www.fesinfo.nl |  | 53. |
| Finnish Association for the Study of Pain
www.suomenkivuntutkimusyhdistys.fi |  | 54. |
| Finnish Pain Association
www.suomenkipu.fi |  | 55. |
| Focus Fibromyalgia Belgium ASBL
www.focusfibromyalgie.be |  | 56. |
| Fondazione ISAL
www.fondazioneisal.it |  | 57. |
| Fondazione ISTUD
www.fondazioneistud.it |  | 58. |
| Fondazione Paolo Procacci
www.fondazioneprocacci.org |  | 59. |
| Foro Español de Pacientes
www.webpacientes.org/fep |  | 60. |

61.  **Foundation Pijn-Hoop**
www.pijn-hoop.nl
62.  **Fundació Acadèmia de Ciències Mèdiques I de la salut de catalunya I de Balears**
www.academia.cat
63.  **Fundación Afectados y Afectadas Fibromialgia y Síndrome Fatiga Crónica**
www.laff.es
64.  **Fundación para la Investigación en Salud (Fuinsa)**
www.fuinsa.org
65.  **Fundación Signo**
www.fundacionsigno.com
66.  **Fundesalud, Consejería de Sanidad de Extremadura**
www.fundesalud.es
67.  **Fundolor**
www.fundolor.org
68.  **Galician Society of Pain and Palliative Care**
www.sociedadgallegadeldolor.sedolor.es
69.  **Geriatric Medicine Society e.V.**
www.geriatric-medicine.org
70.  **Grünenthal GmbH**
www.grunenthal.com

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| German Maltese Medical Society
http://www.germanmaltesecircle.org/gmms.htm |  | 71. |
| Hellenic Society of Algology
www.algologia.gr |  | 72. |
| herescon gmbh
www.herescon.com |  | 73. |
| HRVATSKO DRUŠTVO ZA PALIJATIVNU MEDICINU, HLZ
Croatian Society for Palliative Medicine,
Croatian Medical Association
www.palijativa.com |  | 74. |
| Institute for Research in Operative Medicine (IFOM)
http://www.uni-wh.de/ifom |  | 75. |
| Instituto Aragonès de Ciencias de la Salud
www.iacs.aragon.es |  | 76. |
| Instituto de Estudios de Ciencias de la Salud de Castilla y León
www.iecsfyl.com |  | 77. |
| International Alliance of Patients' Organizations
www.patientsorganizations.org |  | 78. |
| International Headache Society
www.ihs-headache.org |  | 79. |
| International Painful Bladder Foundation (IPBF)
www.painful-bladder.org |  | 80. |

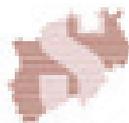
81.  **Irish Pain Society**
www.irishpainsociety.com
82.  **Israel Pain Association (IPA)**
www.ipa.org.il
83.  **Italian Association for the Study of Pain
(Associazione Italiana per lo Studio del Dolore, AISD)**
www.aisd.it
84.  **Italian Society of Neurological Rehabilitation
(Società Italiana di Riabilitazione Neurologica, SIRN)**
www.sirn.net
85.  **Junta de Andalucía Consejería de Salud**
www.juntadeandalucia.es/organismos/saludybienestarsocial.html
86.  **Leon-Castelian Society of Pain
(Sociedad Castellano Léonesa de Dolor)**
www.sociedaddocyl.wordpress.com
87.  **Liga Reumatológica Gallega**
www.ligagalega.org
88.  **Medicinski fakultet sveu ilišta u Zagrebu
centar za palijativnu medicinu, medicinsku etiku i
komunikacijske vještine**
www.mef.hr
89.  **Myeloma Euronet Romania**
www.myeloma.ro
90.  **National Association of Patients with Rheumatoid
Arthritis (ANDAR)**
www.andar-reuma.pt

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| <p>National Council for Palliative Care
www.ncpc.org.uk</p> |  | <p>91.</p> |
| <p>Nederlandse Vereniging van Rugpatiënten
"deWervelkolom"
www.nvvr.nl</p> |  | <p>92.</p> |
| <p>Neil Betteridge Associates</p> |  | <p>93.</p> |
| <p>Netherlands Interstitial Cystitis Patients Organization (ICP)
www.icpatienten.nl</p> |  | <p>94.</p> |
| <p>Neurologiskt Handikappades Riksförbund
(The Swedish Association of Person with Neurological Disabilities)
www.nhr.se</p> |  | <p>95.</p> |
| <p>Osservatorio Italiano Cure Palliative (OICP)
www.oicp.org</p> |  | <p>96.</p> |
| <p>Österreichische Gesellschaft für Geriatrie und Gerontologie
(ÖGGG, Austrian Society for Geriatrics and Gerontology)
www.geriatrie-online.at</p> |  | <p>97.</p> |
| <p>Österreichisches Rotes Kreuz (Austrian Red Cross)
www.rotekruz.at</p> |  | <p>98.</p> |
| <p>Österreichische Schmerzgesellschaft
www.oesg.at</p> |  | <p>99.</p> |
| <p>Painaustralia
www.painaustralia.org.au</p> |  | <p>100.</p> |

101.  **Pain Alliance Europe**
www.pae-eu.eu
102.  **Pain Concern**
www.painconcern.org.uk
103.  **PAIN OUT**
www.pain-out.eu
104.  **Pain Nursing Magazine – Italian Online Journal**
www.painnursing.it
105.  **PAIN South Africa (PAINSA)**
www.painca.co.za
106.  **Palliactief**
www.palliactief.nl
107.  **Palliatives Netzwerk für die Region Aachen e.V.**
www.servicestelle-hospizarbeit.de
108.  **Pain Toolkit**
www.paintoolkit.org
109.  **Patientenschutzorganisation Deutsche Hospiz Stiftung**
www.patientenschuetzer.de
110.  **Pelvic Pain Support Network**
www.pelvicpain.org.uk

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| <p>Plataforma SinDOLOR
www.plataformasindolor.com</p> |  | <p>111.</p> |
| <p>Polskie Towarzystwo Badania Bolu (Polish Pain Society)
www.ptbb.pl</p> |  | <p>112.</p> |
| <p>Portuguese Association for the Study of Pain (APED)
www.aped-dor.org</p> |  | <p>113.</p> |
| <p>Portuguese Association of Palliative Care
www.apcp.com.pt</p> |  | <p>114.</p> |
| <p>Portuguese League Against Rheumatic Diseases (LPCDR)
www.lpcdr.org.pt</p> |  | <p>115.</p> |
| <p>Presidenza della Regione Abruzzo
www.regione.abruzzo.it</p> |  | <p>116.</p> |
| <p>Regional Health Directorate – Azorean Regional Plan for Pain Control
www.azores.gov.pt/Portal/pt/entidades/srs-drs/</p> |  | <p>117.</p> |
| <p>REDE Fm, SFC y SQM
Red Española para la Defensa de los enfermos de fibromialgia, síndrome de fatiga crónica y sensibilidad química múltiple
www.acofifa.org</p> |  | <p>118.</p> |
| <p>Russian Association for the Study of Pain (RASP)
www.painrussia.ru</p> |  | <p>119.</p> |
| <p>Russian Headache Research Society (RHRS)
www.headache-society.ru</p> |  | <p>120.</p> |

121.



SchmerzNetzNRW eG

www.schmerznetznrw.org

122.



Slovak Society for Study and Treatment of Pain

www.pain.sk

123.



Slovensko združenje za zdravljenje bolečine (SZZB)

Slovenian Association for Pain Management

www.szzb.si

124.



Sociedad Andaluza de Geriatria y Gerontología

www.sagg.org

125.



Sociedad Canaria del Dolor (SCD)

www.socadolor.org/es/

126.



Societat Catalana de Medicina Física i Rehabilitació

www.academia.cat

127.



Societat Catalano-Balear de Cures Palliatives (SCBCP)

<http://webs.academia.cat/societats/curespal>

128.



Societat Catalano-Balear d'Oncologia

[www.webs.academia.cat/societats/oncologia/](http://webs.academia.cat/societats/oncologia/)

129.



Sociedad Española Del Dolor

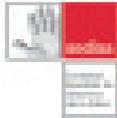
www.sedolor.es

130.



Sociedad Española de Directivos de Atención Primaria (SEDAP)

www.sedap.es

- | | | |
|---|--|------|
| Sociedad Española de Directivos de la Salud (SEDISA)
www.sedisa.net |  | 131. |
| Sociedad Madrileña del Dolor
www.sociedadmadrilenadeldolor.sedolor.es |  | 132. |
| Sociedad Madrileña de Geriatría y Gerontología
www.seqq.es |  | 133. |
| Sociedad Murciana de Dolor
http://murciadolor.com/ |  | 134. |
| Sociedad Valenciana Terapèutica del Dolor |  | 135. |
| Sociedade Portuguesa de Medicina Física e Reabilitação (SPMFR)
(Portuguese Society of Physical Medicine and Rehabilitation)
www.spmfr.org |  | 136. |
| Société Française d'Etude et de Traitement de la Douleur (SFETD)
www.sfetd-douleur.org |  | 137. |
| Society of Pain of Castilla la Mancha
http://sociedadcastellanomanchegadeldolor.sedolor.es/ |  | 138. |
| Spanish Association of Patients with Neuropathic pain, Trigeminal neuralgia and temporomandibular pathology
www.pacientesatm.com |  | 139. |
| Swedish Association for Survivors of Accident and Injury (RTP)
www.rtp.se |  | 140. |

141.



Swiss Headache Society

www.headache.ch

142.



Swiss Association for the Study of Pain (SGSS/SSED)

www.pain.ch

143.



Stichting PijnPlatform Nederland (PPN)

www.pijnplatform.nl

144.



The Work Foundation

www.theworkfoundation.com

145.



Trigeminal Neuralgia Association UK

www.tna.org.uk

146.



Udruženje za Istraživanje i Tretman Bola Srbije (UITBS)

Serbian Association for Pain Research and Treatment (SAPRT)

www.uitbs.org.rs

147.



Ukrainian Association for the Study of Pain

www.pain.in.ua

148.



Universidad Carlos III of Madrid

www.uc3m.es

149.



Universidad Rey Juan Carlos (URJC)

<http://www.urjc.es>

150.



Universidad de los Pacientes

www.universidadpacientes.org

The scientific aims of the SIP 2012 symposium under the responsibility of the European Federation of IASP® chapters have been endorsed by the following large number of pain advocacy and scientific organisations:

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Copenhagen, Denmark
29 - 31 May, 2012

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|--|---|------|
| University of Cádiz
www.uca.es |  | 151. |
| ULSS7 del Veneto
www.ulss7.it |  | 152. |
| Vlaamse Liga voor Fibromyalgie-Patiënten vzw
http://fibromyalgie.be |  | 153. |
| Vlaamse Pijnliga
www.vlaamsepijnliga.be |  | 154. |
| Whiplash Stichting Nederland
www.whiplashstichting.nl | 
WHIPLASH STICHTING NEDERLAND | 155. |
| WIP Foundation
www.wipfoundation.org |  | 156. |
| World Federation for Incontinent Patients (WFIP)
www.wfip.org |  | 157. |
| World Federation of Societies of Anaesthesiologist (WFSA)
www.anaesthesiologists.org |  | 158. |
| World Institute of Pain
www.worldinstituteofpain.org |  | 159. |





**The SIP 2012 symposium took place under the high patronage of
the Italian Presidency of the Council of Ministers and the Italian
Ministry of Health.**

The SIP 2012 symposium was hosted by the Danish Association for Chronic Pain Patients (FAKS). The scientific framework of SIP 2012 was under the responsibility of the European Federation of IASP® Chapters (EFIC®). The pharmaceutical company Grünenthal GmbH was responsible for funding and non-financial support (e.g. logistical support). The scientific aims of the SIP 2012 symposium have been endorsed by a large number of pain advocacy and scientific organisations.

www.sip-platform.eu



The Ethical Committee for the Pharmaceutical Industry in Denmark (ENLI) has been notified of the Symposium. The SIP 2012 Symposium has been pre-approved by ENLI with the current format and content.