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

Background

Research has established that patients with chronic pain deteriorate while waiting for treatment. The deterioration includes escalating pain and depression and decreased health-related quality of life [7]. In addition, an international survey of IASP presidents and other key informants has identified that problems with wait-times for appropriate service or with lack of access to service occur in many nations [6].

On October 11, 2004, during the first Global Day Against Pain, IASP joined with the World Health Organization and the European Federation of IASP chapters in calling for pain control to be recognized as a major public health issue and a human right [1,2]. This initiative was reinforced by the Declaration of Montreal in 2010, which states that access to pain management is a fundamental human right (http://www.iasp-pain.org/PainSummit/Declaration). In keeping with the IASP guiding principle that all people have a right to treatment of their pain, patients should receive timely access to appropriate care for chronic pain.

To address this problem, strong advocacy for this issue will be necessary to influence health care funders and governments who look to health care specialists and the literature for guidance. We believe that two steps are necessary to accomplish this goal:

- The first is to identify appropriate benchmarks for wait-times for treatment of chronic pain and produce a document endorsed by IASP.
- The second is to support and pursue multinational initiatives to address timely and appropriate treatment for the management of chronic pain.

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

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

In summary, Finland, Norway, and Western Australia (with the rest of Australia likely to follow) lead the world with regard to specific government-mandated guidelines for wait-times for treatment of chronic pain. There is significant congruence in the guidelines across nations. Task Force members reviewed and synthesized the information and proposed initial recommendations. IASP Council reviewed these recommendations, and an on-line survey of the membership received responses from 179 members from 57 nations. Many members also sent excellent suggestions and comments. There was overwhelming support for the document. Many comments requested a decrease in wait-times and further clarification. The Task Force has reviewed and included most of these comments and proposes the following recommendations:

Recommendations for Wait-Times[1]

- **Acute painful conditions should be treated immediately** (e.g., sickle cell painful crises and pain related to trauma or surgery[2])
- **Most urgent (1 week):** A painful severe condition with the risk of deterioration or chronicity, such as the acute phase of complex regional pain syndrome (CRPS), pain in children, or pain related to cancer or terminal or end-stage illness.
- **Urgent or semi-urgent (1 month):** Severe undiagnosed or progressive pain with the risk of increasing functional impairment, generally of 6 months' duration or less (back pain that is not resolving or persistent postsurgical or post-traumatic pain).
- **Routine or regular (8 weeks):** Persistent long-term pain without significant progression.

Additional Recommendations

1. It is acknowledged that in order to accomplish these recommendations, there will be a need to increase the capacity for access to appropriate pain management in all nations. Given the problem with lack of access to treatment, it is recommended that IASP support multinational initiatives to build the capacity to provide timely and appropriate treatment for the management of pain, both acute and chronic.
2. In proceeding with this recommendation, it will be necessary to address quality control, because at present there is wide variation in the nature of care. Thus, standards of care need to be developed and adopted, or where good standards exist, they need to be endorsed. At present, IASP provides an excellent document for development of clinical practice guidelines. The IASP "Recommendations for Pain Treatment Services" states that clinicians should be aware of all relevant treatment guidelines, but it stops there. Guidelines are needed for many key conditions, such as low back pain, headache, CRPS, surgical/postsurgical pain, chronic visceral pain, and fibromyalgia. The American Pain Society appears to have made the most progress in this area (http://www.ampainsoc.org/pub/cp_guidelines.htm). IASP should provide guidance on this issue.
3. It will be necessary to consider cost-effective appropriate treatment of pain, including:
    - Include chronic disease self-management approaches in chronic pain treatment [3–5,8].

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[1] Wait-times refers to time from referral to treatment, and it is acknowledged that it is also important to improve the time between the onset of the pain and the time of referral.
[2] Acute herpes zoster should also be treated immediately or as soon as possible in order to prevent the onset of postherpetic neuralgia.

- Develop initiatives to improve education of community and primary care practitioners regarding management of pain.
- Encourage, enhance, and facilitate consultation networks between professionals (e.g., tele-health, electronic communications).
- Support initiatives to increase multidisciplinary teams for pain treatment.
- Develop pathways of care for referral through primary, secondary, and tertiary levels of care, to assure the most appropriate and efficient use of limited resources.
- Pursue strategies to address/limit re-referral rates of patients with chronic pain whose status remains unchanged, i.e., identify an "end-point."

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

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Table 1 Benchmarks for wait-times for pain treatment in countries that have guidelines				
	Most Urgent	Urgent or Semi-urgent	Routine or Regular	Comments
Australia (Department of Health, Western Australia)	“immediate” “category 1” **1 week** Acute, painful, severe condition with risk of deterioration and impaired quality of life (e.g., cancer, new-onset CRPS, acute zoster)	“urgent” “category 2” **1 month** A painful condition of intermediate duration with progression and a risk of increasing functional impairment (e.g., acute back pain becoming chronic)	“routine” “category 3” **3 months** Persistent long-term pain, rapid progression unlikely, maintenance treatment started or review/ reassessment has become necessary (e.g., postherpetic neuralgia, chronic low back pain, persistent pain, long-term opioid use requiring a renewal of authorization)	It is acknowledged that the routine wait-list in Western Australia is currently 12 months due to limited facilities; opioid authorizations are extended if a referral has been initiated
Canada (Wait Times Alliance Recommendations, published November 2007)	**14 days** Cancer pain	**30 days** Acute neuropathic pain for less than 6 months	**3 months** Acute lumbar disk protrusion or subacute chronic pain in an adult of working age where intervention may improve function	6 months for other types of chronic pain
United Kingdom (government mandated)			**18 weeks** from referral to treatment for all conditions in outpatient clinics	These guidelines are generic and not specific to pain
Finland (government mandated)	**1 month** for severe undiagnosed pain or prolonged post-traumatic or postsurgical pain	**3 months** for moderate undiagnosed pain	**6 months** for non-urgent care of chronic pain	In Finland, this government-mandated access to health care was extended to chronic pain in March 2007
Norway* (guidelines published by the Norwegian Directorate of Health, June 2009)	**2 weeks** **Group 1** or subacute pain conditions that have lasted more than 6 months and may develop into difficult-to-treat pain **Group 5** or severe and difficult-to-treat pain in known serious and advanced illness (e.g., cancer, heart failure, end-stage multiple sclerosis)	**16 weeks** **Group 2** or chronic complex pain with or without a known initiating cause and no longer curable and comorbid problematic drug use or psychiatric illness	**16 weeks** **Group 3** or chronic complex pain with a known initiating cause that is no longer curable **Group 4** or chronic complex pain condition without a known initiating cause	These wait times apply to those deemed to have a legal right to treatment
*In Norway, patients are triaged into five groups. An application by the primary care physician for pain clinic treatment must be evaluated within 30 days of receipt. Wait-time is the time between the evaluation of the application and medical treatment.				