Haut Conseil de la Santé Publique

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Evaluation of the National Program for improving pain management 2006 - 2010

Summary

March 2011

On May 7th 2010, the French Ministry of Health requested the French High Council for Public Health (HCSP) to drive the evaluation of the 2006-2010 pain program. An evaluation committee was settled, made up of two HCSP members, five external personalities and two members of the HCSP general secretariat. The committee proceeded by hearings: 35 individuals were interviewed and 16 provided written contributions. At first, the committee studied the level and methods for achieving the 25 predispositions of the program divided into four main priorities. It then performed a general evaluation of the structuration and progress of the program. It concluded with a series of recommendations that could help to set up a new pain program. To conclude, observations and assessments were proposed as follows.

Priority 1: Improving pain management in the most vulnerable populations

Children and teenagers

The recommendations on the good practices for pain medication in children, provided by the France's regulatory agency for healthcare products (Afssaps), were considerable advances. These form a reference document to guide professionals in their daily practice. However, these recommendations would deserve to be better circulated among healthcare professionals. Major efforts were made in care and prevention of acute pain, particularly due to healthcare. But genuine difficulties remain regarding the access to specialist advice on chronic pain management - which is not limited to cancer (headaches, rheumatology, neuropathic pain, motor handicap, etc.): the number of consultants and specialized centers is very lower than needs, with a very insufficient access to non-pharmacological techniques, particularly psycho-behavioral. The use of adult medicinal products in pediatrics is still to be developed, even though the pediatric marketing authorization (MA) does exist in other countries, at least for some of them. Information for families and children must be more widely distributed. Generally speaking, the impact of disposal planned by the pain programs is insufficiently assessed, urging on the development of epidemiological research.

Elderly

An overview of pain management in the elderly was carried out, but prior to the program and its spreading - limited to the geriatric community - remains insufficient. Significant efforts were made to train nursing staff through a systemic approach so as to improve: (1) the detection and management of pain, (2) the prescription of psychoactive substances, (3) the promotion of positive treatment, (4) the account of mental suffering and (5) the awareness of staff working in geriatric institutions regarding the palliative approach. For the most part, the set up plan is based on the Mobiqual project, via the creation and the distribution of training kits for training leaders. The available evaluations of this project were conducted by the project promoters themselves, using questionnaires that have been completed and returned by professionals who used the kits. Given the project’s ambition and budget (1 million €), an independent, professional evaluation would have been highly preferable. Nevertheless, a real effort was made to spread the recommendations and create a “pain culture”. This effort was mainly focused on geriatric institutions and very little was done for elderly living at home, although 90% of over 75s live at home with one

on two complaining about pain. Training sessions for GPs and home care professionals (nurses, physiotherapists) - nay daily living nursing - are crucial to ensure better use of painkillers, knowledge of iatrogenesis and use of techniques not involving medication.

Other vulnerable people: handicap and psychiatry
Disabled people and mental sufferers were neglected by the program. Very few disposals concerned the former and none the latter, despite pain being very much an issue for such populations: in a recent survey called “un jour donné” (“a given day”) by the pain clinic in Saint Jean de Dieu Hospital, Lyons, 60% of the 245 inpatients complain of pain, yet only 14% were assessed by nursing. Investigations are essential on measuring tool adapted to different mental illnesses.

Priority 2: Training

Progress were made in the 2006-2010 pain program to improve practical initial training and continuing education for healthcare professionals (Further specialized study diploma [DESC] in “pain medicine, palliative medicine” as well as new specialized university or inter-university [DIU] diplomas, evaluation of professional practices, etc.). However, their impact was tempered by the persisting limitations in terms of hospital positions and practice conditions for private pain consultants - unlike the palliative care sector. It should be pointed out that there is still much to do in this area, especially since the training framework is changing: reform of higher education courses in harmony with European courses (called the Bachelor-Master-Doctorate reform, LMD) and continuous professional development. Training programs now focus on the acquisition of vocational skills requesting students and professionals to learn to proceed in a clinical situation. Pain clinics must improve their communication with private medicine (emergency appointments, electronic filing, Internet connection, etc.) and, more generally, provide clearer explanations of the multidisciplinary and multidimensional treatment approach.

Priority 3: Improving practices of treating for high-quality pain management

Unquestionably efforts were made as regards to the good professional practice recommendations on pain induced by medical procedures in children (2009) and intractable pain in palliative situations in adults, with the home use of certain molecules with exclusive dispensation by hospital pharmacies (2010). Two major epidemiological studies conducted by the French National Resource Centre for Pain Prevention (CNRD) - (1) the EPIPPAIN study in the Parisian region on the prevalence of painful and stressful care and pain-relieving treatments administered in neonatal and pediatric intensive care and (2) the REGARDS study on the prevalence of painful and stressful procedures in geriatrics - make significant contributions for taking action to limit pain-inducing treatment, even though they have not been explicitly included in the national program.

On the other hand, knowledge concerning the non-pharmacological methods little progressed. There are still many obstacles to the development of the not medicinal

therapies. There is no real political will to overcome the main obstacle posed by the remuneration that the French Health Insurance System has enforced on non-medical professionals. It is still very difficult to assess techniques as osteopathy, auriculo-therapy, art therapy, support groups, etc. in the management of chronic pain and studies like those funded by the third program (transcutaneous neurostimulation for lumbago sufferers and relaxation during migraines) should be encouraged.

Priority 4: Structuring the pain care sector

The regional structuring and organization of the intractable chronic pain treatment collided with a lack of means, political initiative and scoping. The overall observation at the end of the program remains an increasingly precarious situation of the pain clinics. Some have lost personnel under the pressure of hospital restructuring while others never received their allotted funding, delegated to their hosting hospitals. Access to intractable chronic pain clinics remains difficult, the waiting delays being long. The update of the specifications of the pain clinics is delayed - this document should be published only in 2011.
Moreover, one of the limitations is the highly “hospital-centered” approach of the program, largely targeted at structuring the intractable chronic pain clinics. Support for private pain consultants did only concern the preservation of the rare physician-hospital networks that already exist. Beyond an attempt to develop training tools in geriatrics, no thought concerned a closer involvement of primary care medicine. In spite of the lively interest carried in networks, they still remained at the experimental stages, involving few professionals and patients. Psychological care also remained neglected.
As an only slight improvement, the requirement on hospital treatment quality provided by the French National Authority for Health (HAS) seems to be fruitful. Accreditation followed by certification - with pain selected as one of the “required priority practices” which are key criteria for improving the quality and safety of health care through certification - provided an undeniable support to Pain Prevention Committees (CLUDs) and nursing staff involved in pain management. Indicators for improving care quality and safety in healthcare institutions (IPAQSS) pinpoint efforts made in evaluating and monitoring identified pain. The evaluations of professional practices, particularly through audits or multidisciplinary discussion meetings (RCP), are promising tools for eliciting a dynamic and showing to the teams that their commitment/involvement is worthwhile.

General assessment

The evaluation committee shared out the program disposal within two categories: those aimed at improving the conditions for managing pain (training, drafting of recommendations, epidemiological research) and those more directly concerning the improvement of pain management *per se* (centers, employees, painkillers or pain-relieving techniques, etc.). Most progress concerned the first category of disposals.

In financial terms, €21.4M (out of the €26.7M budgeted) were invested. No support was allocated to create new networks. It was impossible to establish whether the

funds intended to finance the setup of the pain healthcare resource group (GHS in France) were expended, given the low incentive associated with coding. It turns out that the amounts included in the program but funded by “ordinary” funds (health insurance, MIGAC) are not under control.

According to financial data transmitted via the “ARBUST MIGAC” system by the regional hospitalization agencies (ARHs) to the General Directorship for Health Care (DGOS), the financial flow associated with pain increased from 51.7 to 62.6M Euros (i.e. by €10.9M) in the 2006-2009 period. In view of this amount, can one claims that pain management was funded well beyond what the national program anticipated, insofar the endowments of the structures increased during the duration of the program? However, in terms of human resources, the testimonies from the specialists pointed more cancellations than creations of jobs. Under reserve of a balanced assessment of the real use of the credits, this implies that this money was probably used for other purposes within healthcare settings.
One can therefore conclude that the third program had a major impact on the hospital professional environment in terms of animation or encouragement for innovation, while it missed its objective of improving treatment by not taking sufficient account of the following exogenous constraints:
- the organization and funding of the public hospital;
- the relative isolation of liberal medicine;
- the limited impact of incentive for the pharmaceutical industry to develop new galenical forms of painkillers and to apply for MAs;
- the remuneration conditions provided by the French health insurance system to medical and non-medical professionals. Experiments of fixed coverage decided by pain clinics, which included the liberal treatments in the private sector, would allow the development of a network of care useful for the patients, the remuneration for the psychologists and non-medical professionals, the establishment of an educational link between professionals, together with a bigger availability of pain clinics.

After the Hearings and beyond the already mentioned recommendations made on the basis of the objectives and disposal of the 2006-2010 program, the mission considered it worthwhile to propose a new program based on four principles and six main recommendations:

Four principles and six main recommendations:
Principle 1: Strengthen and deepen the advances of the previous programs; fill the gaps.
Principle 2: Shift the paradigm from hospital-centered care and knowledge towards the offer and an organization of the city care, that is a high-quality offer in both the hospital and in town.
Principle 3: Pay close attention to people who cannot communicate (newborns and very young children, patients in intensive care, patients suffering from mental disorders, patients with multiple disabilities and patients suffering from dementia-type disorders).
Principle 4: Elaborate and drive the future program according to clarified objectives and proportioned resources, with the implementation of a real piloting function.

Recommendation 1: Continue to structure the offer of health care options, particularly in the private sector
Recommendation 2: Healthcare professionals training and raising awareness
Recommendation 3: Information of the public
Recommendation 4: Pay particular attention to children, teenagers, elderly, disabled and people suffering from mental disorders.
Recommendation 5: Improve knowledge (epidemiology, clinical research, impact assessment).
Recommendation 6: improve governance.

As a result, a particular attention should be dedicated to the piloting of the program, both in terms of coordination and follow-up, with:
- Ministerial coordination involving the General Directorship for Health (DGS), DGOS, the Social Security Directorate (DSS) and the Directorship for Research, Studies, Evaluation and Statistics (Drees), with the aim of taking into account all dimensions of the problems, namely political, structural, financial and evaluative.
- An activated follow-up committee, with groups working on each main recommendation;
- The definition, as early as the drafting stages, of follow-up indicators, including financial, for each section of the program.
- A public annual activity report.

This is the reasons why the HCSP recommends the development of a fourth pain program in order to give a new breath to the already undertaken actions and make sure of the continuation of the commitment of public authorities to this field.
The strengthening of the requirement of the public in the field of pain relief passes by an extensive and regular information. This requirement is a key determining factor of the change in the professional practices. It is an essential element which requires a political will explicitly shown at the ministerial level.