

Access to Pain Management as a Human Right

The concept of access to pain management as a human right has gained increasing currency in recent years. Commencing as individual advocacy, it was later embraced by the disciplines of pain medicine and palliative care and by mainstream human rights organizations.

Today, United Nations and regional human rights bodies have accepted the concept and incorporated it into key human rights reports, reviews, and standards. We review the foundations in law of this right and the obligations that flow from it to governments. We analyze the nature and content of the obligation in the context of acute, chronic non-malignant and cancer pain.

Finally, we examine this right in light of the twin crises of inadequate access to pain management and the opioid crisis in the United States and other nations. (*Am J Public Health*. 2019;109:61–65. doi:10.2105/AJPH.2018.304743)

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See also Carr et al., p. 17; and also the *AJPH Pain Management* section, pp. 30–72.

“Pain-relief treatment . . . is a fundamental human right.”
—M. A. Somerville^{1(p215)}

“I put it to you that the relief of severe, unrelenting pain would come at the top of a list of basic human rights.”
—M. J. Cousins^{2(p541)}

These early statements linking pain management and human rights were, in many ways, cries in the dark. The authors, conscious of the enormous global burden of pain and its widespread undertreatment, reached toward a language of universality and responsibility that reflected their sense of urgency. To each, that language was best represented in terms of human rights. Since the 1990s, the notion of access to pain management as a human right has gained significant currency as both legal and public health experts have sought to unpack its dimensions, implications, and limitations.^{3–5} Though no longer novel, the concept of the human right to pain management remains an evolving one that warrants further examination and analysis.

We examine the foundation of the concept of access to pain management as a human right and its implications for medicine. We argue that certain obligations flow from this right for governments to fulfill. We analyze the extent and nature of this obligation in the contexts of acute, chronic noncancer and cancer pain and the specific context of the current opioid crisis in the United States and other nations. Finally, we argue that principles of human rights dictate that pain

management be an integral component of Universal Health Coverage (UHC), a critical objective of the World Health Organization (WHO).

BACKGROUND

The International Association for the Study of Pain defines pain as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.”⁶ The causes of pain are often classified as acute pain (the pain related to trauma, including burns and bone fractures, labor pain, and operative and post-operative pain), cancer pain, and chronic noncancer pain (CNCP).

The global burden of pain is very significant.^{7,8} The management of pain requires a broad and multidisciplinary approach that addresses its physical, psychosocial, and spiritual dimensions.⁹ Treatment approaches vary depending on the type and nature of pain. Opioids have a pivotal role in the management of moderate to severe acute and cancer pain. In CNCP, their role is more limited although required in certain circumstances.

Despite the prevalence of pain and its impact on quality of life,

undertreatment remains a major problem. There are many barriers to pain management: inadequate access to health facilities, lack of training of health professionals,¹⁰ lack of acknowledgment of pain,¹¹ and racial biases.¹² The opioid crisis in the United States has resulted in restrictions with regard to legitimate access to opioid medication and inadequate pain control for patients.¹³

Globally, one of the greatest and persistent issues in pain management is the disparity in access to opioid analgesics.¹⁴ Multiple factors contributed to this situation, including national opioid laws with a predominant focus on illegal drug use and tight regulation of opioids for medical purposes. Of the total global use of morphine for medical purposes, 92% is used in nations that contain only 17% of the world’s population.¹⁵ In the words of the president of the International Narcotics Control Board,

Despite the progress made in some regions, the fact remains that approximately three quarters of the world’s population live in countries with inadequate or non-existent access to medicines containing narcotic drugs . . . which leads to unnecessary pain and suffering.¹⁶

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THE RIGHT TO PAIN MANAGEMENT

The ethical responsibility of clinicians to manage pain is well understood and a basic element of ethical codes. For instance, the American Medical Association states that “Physicians have an obligation to relieve pain and suffering,”¹⁷ and the World Health Assembly resolved that “[I]t is an ethical duty of health care professionals to alleviate pain and suffering.”¹⁸ In response to the major gaps in treatment, pain and palliative care professional associations went further and made a series of declarations asserting that pain management and palliative care are basic human rights. (A summary of those statements is presented in the box on page 63). Although there may be a moral obligation to manage pain, is there a basis for a right to treatment of pain in human rights law?

Human rights are entitlements and freedoms that all human beings hold, regardless of nationality, ethnicity, gender, or religion. Internationally, human rights are founded on recognition of the inherent dignity of the human person and expressed in international human rights conventions. Internationally, the foundations for the assertion of pain management and human rights lie in the international right to health; the right to be free from cruel, inhuman, and degrading treatment; and the principles of dignity, nondiscrimination, and equality. The relevant sources are summarized in the Appendix (available as a supplement to the online version of this article at <http://www.ajph.org>).

The principal articulation of the international right to health is Article 12 of the International Covenant on Economic, Social and Cultural Rights.¹⁹ The

covenant does not contain an express right of access to pain management. Nevertheless, pain management forms part of health care and, as such, falls within the overall right to health. The covenant obliges state parties to fulfill this right to the “maximum of their available resources.”²⁰ The committee that oversees the covenant stated that the right to health includes the following: the availability of health goods and services; accessibility of health services to all citizens; and acceptability in terms of culture and religious beliefs and quality in terms of skills and expertise.²¹ Each of these components applies to all aspects of health care, including pain management.

The committee identified a number of “core obligations” that countries must fulfill, irrespective of their resources.²² They include obligations to ensure access to health facilities, goods, and services on a non-discriminatory basis, to provide essential medicines as defined by the WHO, and to adopt and implement a national public health strategy. The committee also enumerated obligations “of comparable priority,” which include providing education and access to health information to the community and “appropriate training for health personnel.”²³ These requirements mean that countries should fulfill each of these elements in terms of pain management.

It is important to distinguish the right to pain management under human rights law, where obligations rest on governments, and under medical ethics, where obligations rest on individual clinicians. Those sets of obligations converge to the extent that governments have a responsibility (as part of the right to health) to ensure the adequacy of medical education, and (as part of their

fulfillment of the quality of health care) they have within their power the licensing of physicians.

In addition to the right to health, there are statements by senior UN human rights officials that the failure to ensure access to controlled medicines for the relief of pain and suffering threatens the protection of persons from cruel, inhuman, and degrading treatment.²⁴

CHRONIC NONCANCER PAIN AND HUMAN RIGHTS

Much has been written about the human rights dimensions of pain management in the context of acute and cancer pain and, more generally, palliative care.^{3,25} Analyzing the specific obligations that flow from the right to health for CNCP management is arguably more complex. Firstly, CNCP is a broad term that includes many different pain syndromes of different etiologies that require different types of treatment.²⁶ Unlike cancer pain, where the WHO has clear and detailed clinical guidelines that focus on pharmacological treatment, treatment approaches for CNCP are far more diverse and no WHO clinical guidelines exist for adults. Moreover, for many types of CNCP the evidence of most effective treatment modalities is relatively weak, complicating efforts to determine whether pain treatment services meet the quality requirement under the right to health.

Secondly, although opioid analgesics play a central role in acute and cancer pain management, the same is not necessarily true with CNCP. There is a wide array of treatment modalities, including both pharmacological and nonpharmacological

interventions, and CNCP often requires a multidisciplinary approach that combines several of these modalities to be effective.⁹ Yet only some of the medicines used in CNCP management—and, of course, none of the nonpharmacological interventions—are included in the WHO Model List of Essential Medicines.

Even so, several core obligations related to CNCP management still flow from international human rights norms. Firstly, as CNCP is a major contributor to the global burden of years of life disabled, all countries must develop and implement a strategy that responds to this health need. The level of ambition of such strategy will be dependent on a country’s resources but must match the maximum available resources. Secondly, medications that are included on the WHO’s Essential Medication list, including nonsteroidal anti-inflammatory drugs, muscle relaxants, antidepressants, and opioid analgesics that are frequently used in the management of CNCP, must be available and accessible to all patients who need them. Finally, countries must ensure that health care providers receive adequate training in the management of CNCP.

Although fewer obligations flow from the right to health for CNCP, the basic obligation for states to “respect, protect and fulfil” the right to health and to ensure that health services are available, accessible, acceptable, and of good quality still applies.²⁷ However, those obligations are subject to progressive realization, which makes the determination of whether a state respects the right to health more complicated as a decision has to be made whether it has ensured services for CNCP to the “maximum of its available resources.”²⁰

INTERNATIONAL STATEMENTS ARTICULATING PAIN MANAGEMENT OR PALLIATIVE CARE AS HUMAN RIGHTS AND THEIR SPONSORING ORGANIZATIONS

Pain Management

Global Day Against Pain (2004)—International Association for the Study of Pain (IASP), European Chapters of the IASP (EFIC), World Health Organization (WHO)

Global Day's theme: "The Relief of Pain Should Be a Human Right."

The Panama Proclamation: Proclamation of Pain Treatment and the Application of Palliative Care as Human Rights (2008)—Latin American Federation of IASP Chapters, Foundation for the Treatment of Pain as a Human Right.

Joint Declaration of and Statement of Commitment to Pain Management and Palliative Care as Human Rights (2008)—International Association of Hospice and Palliative Care (IAHPC), Worldwide Palliative Care Alliance (WPCA)—Articulation of both pain management and palliative care as human rights based on international human rights conventions.

The Declaration of Montreal (2011)—IASP:

"and recognizing the inherent dignity of all persons and that the withholding of pain treatment is profoundly wrong, leading to unnecessary suffering that is harmful, we declare that the following human rights must be recognized throughout the world:

"Article 1. The right of all people to have access to pain management without discrimination.

"Article 2. The right of all people to have acknowledgment of their pain and to be informed about how it can be assessed and managed.

"Article 3. The right of all people in pain to have access to appropriate assessment and treatment of the pain by adequately trained health professionals."

Council of the World Medical Association (WMA) (2011)

The Morphine Manifesto (2012)—Pallium India, IAHPC, Pain and Public Policy Studies Group, University of Wisconsin/WHO Collaborating Center for Pain Policy and Palliative Care (PPSG), and 60 other organizations.

Palliative Care

The Cape Town Declaration (2002)—African Palliative Care educators

International Working Group (European School of Oncology) (2004)

The Korea Declaration (2005)—2nd Global Summit of National Hospice and Palliative Care Associations

The Panama Proclamation: Proclamation of Pain Treatment and the Application of Palliative Care as Human Rights (2008)—Latin American Federation of IASP Chapters, Foundation for the Treatment of Pain as a Human Right.

Joint Declaration of and Statement of Commitment to Pain Management and Palliative Care as Human Rights (2008)—International Association of Hospice and Palliative Care (IAHPC), Worldwide Palliative Care Alliance (WPCA)

The Lisbon Challenge (2011)—European Association of Palliative Care (EAPC), IAHPC, Human Rights Watch (HRW)

The Prague Charter (2013)—EAPC, IAHPC, WPCA, HRW

In light of the current opioid crisis in the United States, it is important to point out that the right to pain management does not imply an automatic right to opioid medications. A criticism leveled at the concept of human rights and pain management is that the right appears to give free rein for patients to say, "You must give me opioids—that is my right." In fact, the right to health requires "quality" of services in terms of skills and expertise in addition to availability, accessibility, and acceptability. Those skills and expertise require a conscientious assessment of pain

and development of a treatment plan, guided by the best evidence available, but that plan does not include providing opioids on demand. The evidence shows that in some pain syndromes—for instance, acute pain and cancer pain of moderate to severe intensity—strong opioids are recommended.²⁸ In CNCP syndromes, however, opioids may play a more circumscribed role.²⁹ The right to access pain treatment means that physicians should be able to make the clinical determination of the best treatment options—without inappropriate government

interference—and patients should have access to them, including opioids. Implicit in the human right to pain management is the obligation on governments to progressively realize the careful, reasonable, and conscientious provision of pain management.

PAIN MANAGEMENT AND UNIVERSAL HEALTH COVERAGE

Pain management is a quintessential clinical imperative—it

is the main motivation for people to see a health care worker. It is also a significant public health issue that requires an appropriate response. A public health approach aims to protect and improve the health of a community by incorporating knowledge and skills into evidence-based, cost-effective interventions that will be available to everyone in the population who needs them.

In recent years, the international community has strongly promoted the concept of UHC, which seeks to ensure that

all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.³⁰

In 2005, the World Health Assembly called on all member states to implement UHC.³¹

Attention to pain management in discussions of UHC has been limited to date, as much of the focus has been on communicable diseases and child and maternal health. However, given the burden of disease caused by pain—whether acute, cancer, or chronic noncancer pain—human rights norms require that pain management be incorporated as part of the basic health package that countries offer under their UHC schemes.

THE INTERFACE OF HUMAN RIGHTS AND THE OPIOID CRISIS

Globally, there are four strikingly different challenges with opioids. The first is access. The vast majority of the world's population lives in countries with limited or negligible access to morphine for medical purposes. The second is that pain management often requires the use of controlled medications. Thus, drug control policies and practices must ensure adequate access to these substances. The third is a rise in opioid-related deaths, with a complex etiology predominantly driven by polypharmacy, heroin, and synthetic fentanyl. The fourth is the restriction, directly or indirectly, of pain management in patients with genuine needs. All are pressing issues. If one of these is embraced as the singular

challenge and the others are ignored, great harm is likely to flow. Governments, regulatory authorities, clinicians, and society should focus on all issues simultaneously.

In addition to pain management, the health needs of persons with opioid use disorder also have both a public health and human rights dimension. In terms of the crisis in opioid misuse, there is a tension between two paradigms: prohibitionism, the dominant theme of the international drug control treaties,^{32–34} and the health needs of persons with opioid use disorder. Under international human rights law, states have an obligation to respect, protect, and fulfill the right to health of all people, including those who use drugs. That obligation includes two principal duties. The first is to implement harm reduction measures that are known to protect and promote the health of persons who use drugs.³⁵ The second is to ensure that legislation or policies do not cause or contribute to the harms experienced by this cohort.³⁵

The UN special rapporteur on health has stated that harm reduction measures, such as Medication Assistance Treatment programs, “constitute a legal obligation as part of the right to [health]” and “urge[d] states to commit the maximum available resources” to such programs.³⁶

In these areas, there is confluence of responsibilities. Governments have a responsibility both to protect people against the potential harmful effects of controlled substances and to ensure that people who use them have access to appropriate health services. One of the dangers of a highly regulatory response to the opioid crisis is an arbitrary restriction of access of opioids to patients who genuinely require them, which may constitute a

violation of human rights. Governments must ensure that clinicians are adequately trained in both pain medicine and management of drug dependence. Currently, there are significant deficits in their training in both disciplines. Without training, myths persist. A right to pain management mandates a conscientious and rational approach to the management of pain that may or may not include opioids. A rights-based discourse significantly expands the emphasis from medical to legal obligations under national and international law. Equally, vigilance regarding opioid diversion and abuse and appropriate, evidence-based management of drug dependence remains vital. Striking that balance challenges all involved to ensure that access to effective pain management is a reality. **AJPH**

CONTRIBUTORS

Each of the authors contributed substantially to the content of the commentary.

CONFLICTS OF INTEREST

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