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DIVISION OF DISEASE PREVENTION AND CONTROL
PROGRAM ON NON-COMMUNICABLE DISEASES

FRAMEWORK FOR A REGIONAL PROJECT ON CANCER PALLIATIVE
CARE IN LATIN AMERICA AND THE CARIBBEAN

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PALLIATIVE CARE IN LATIN AMERICA AND THE CARIBBEAN

EXECUTIVE SUMMARY

The number of cancer patients in the region is increasing, if the present trend continues, it can be estimated that by the year 2000 nearly a million persons in Latin America and the Caribbean will need palliative care services.

Cancer palliative care is active total care of patients with advanced disease, whereby emphasis is placed on home care and primary care centers, which reduces hospitalization and emergency room utilization. Pain management is the cornerstone of palliative care, but also the control of other symptoms and psycho-social support for the patient and the family plays an important role. The goal is to achieve the best quality of life possible for the patient with effective utilization of the available resources.

The major barriers in the implementation of palliative care programs are:

- lack of recognition of advanced disease as a public health problem
- insufficient knowledge of primary health care professionals on how to adequately manage pain and other symptoms related to advanced disease
- barriers in legislation which interfere with the accessibility and use of opioid analgesics
- lack of outpatient facilities and programs to adequately provide guidelines and care for persons with advanced disease, resulting in over-utilization of emergency care units, intensive care units and third level hospitalizations

Palliative care is often ignored by health care personnel and when offered, is usually too late in the course of the disease. Instead, palliative care needs to be seen as an integral part of cancer care, initiated at the diagnosis. It is not only a matter of clinical decision making; it is also a matter of national policy, in that education, drug availability and legislation are necessary. In Latin America and the Caribbean, even countries with large health care infrastructure, do not provide equal access to palliative care services to its population, as suggested by the internationally accepted indicator of morphine consumption, which is less than 1 mg. per capita, while in the United States and Canada is higher than 20 mg per capita.

The Program on Non Communicable Diseases at the Pan American Health Organization is proposing a field demonstration project, based on current scientific knowledge, to develop a cost-effective intervention model in palliative care for Latin America and the Caribbean.

Introduction

Palliative care is defined as “the active total care of patients with advanced disease. Control of symptoms, especially pain, is fundamental. The goal of palliative care is the achievement of the best quality of life for patients and their families”.ⁱ

In 1985, 595,000 new cancer cases were diagnosed in Latin America and the Caribbeanⁱⁱ. However, currently, few resources are allocated to cancer prevention and control. While other problems have occupied the health agenda, malignant neoplasms continue to be the second leading cause of death in most countries of the Region. It has been estimated that the increasing exposure to risk factors and an aging population, will increase the case load at a rate of 34% every ten years.ⁱⁱⁱ

For over a decade the World Health Organization’s Global Cancer Control Program has emphasized the following priorities: cancer prevention, early detection linked with effective treatment and palliative care.^{iv} Cancer prevention and particularly early detection are currently a major concern for PAHO in the development of the cancer program in the Americas; however, palliative care has not been fully addressed yet.

In many countries costly curative oncology procedures and treatments are available to a few, with little benefit to the patient, often doing more harm than good, and representing large expenses to the health care system. Palliative care is not an alternative to treatment, it is part of a more rational disease management strategy. The concept of palliative care relates to quality of life and quality at the end of life for individuals with the disease and their families. Its implementation is subject to major policy decisions at the governmental level and actions at the local level. In this document the overall situation of the Region is presented; the role of PAHO in policy making is discussed.

Palliative care is also strategy that addresses inequities in the access to complex health care. Examples are provided where a simple local intervention to those in need can bring about important changes in the end of life. Ethical aspects of a palliative care program are also presented herewith.

Project Profile

Goal To provide cost-effective palliative care services to all persons who need it.

Strategy

- PAHO will provide information to assist countries in the adoption of a national policy, that would bring about changes in legislation to incorporate palliative care and pain relief as a public health issue, ensuring the availability of appropriate drugs, especially analgesic opioids; as well as, a commitment from Ministries of Health to allocate the necessary resources to implement decentralized palliative care programs.
- Promote a regional network of groups working in palliative care, which would include the groups previously supported by the WHO's Global Cancer Program, non-governmental organizations, public and private institutions, as well as lay organizations. Special efforts will be made to develop an interface between these groups and policy makers.
- Develop selected field demonstration projects to evaluate cost-effective options for decentralized palliative care programs. These projects would be carried out in countries with the necessary conditions for drug availability and with decentralized health care system.

Expected results:

- All countries have appropriate legislation and regulations that warrant equal access to palliative care to all persons who need it.
- Availability of morphine in primary care settings
- Decrease utilization of hospital and emergency room services by persons with advanced cancer.

Impact Measures:

- At least 80% of countries in the Region of the Americas report morphine consumption at or above 10 mg per capita.
- At least 30% reduction in days of stay per hospital discharge with a diagnosis of cancer
- At least 50% of death certificates with mention of cancer, have received medical care and have died at home.

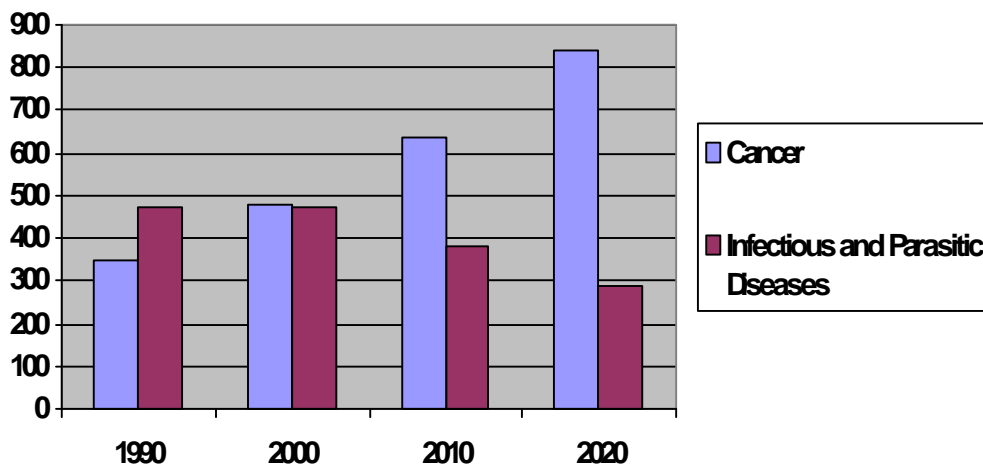
Process Indicators:

- Information packet for policy makers developed .
- Meetings to discuss palliative care policy held in each country
- Analysis of legislation and regulation shows that barriers to drug availability have been abolished
- Adoption of the World Health Organization Palliative Care guidelines
- A minimum of three demonstration sites are ongoing in the Region
- Home care is provided for >70% of persons with advanced cancer in demonstration sites
- General practitioners and nurses have received continuing education in palliative care
- Cancer patients and/or their immediate family have received education on palliative care
- Pain control has improved for those participating in palliative care programs
- Improvement in quality of life for those participating in palliative care programs
- Utilization of emergency room and hospitalization has decreased for those participating in palliative care programs
- Cost-effectiveness analyses of interventions at demonstration sites have been discussed with policy makers
- Information packet has been updated and expanded to include new findings and recommendations.

Situation in Latin America and the Caribbean

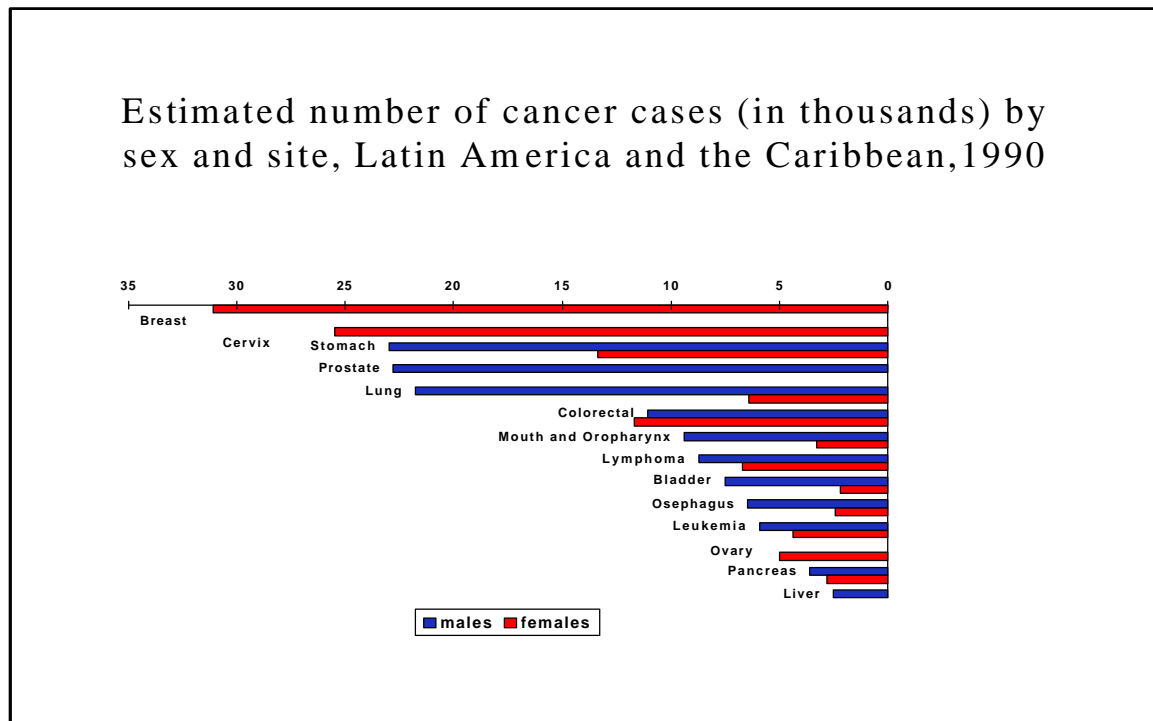
The number of cancer patients in the world has been increasing and is expected to continue to rise in most regions of the world, mainly because of aging of the population and increases in tobacco consumption and other risk factors. If the present trend continues, it can be estimated that by the year 2020 almost one million persons in Latin America and the Caribbean will need palliative care services³.

**Number of Deaths and Mortality Projections (in thousands)
In Latin America and the Caribbean**



Among females cancer of the breast and cervix contribute the majority of the caseload². In males stomach, prostate and lung are the leading sites. Colorectal cancer is slightly increasing at the same time that stomach cancer is experimenting a decreasing trend in most countries. Possibilities for primary prevention are significant for smoking related cancer, if tobacco control policies succeed in reducing prevalence of smoking^v, nonetheless, even if the latter occurred, there would always be a lag time of approximately 20 years to have an impact on cancer mortality. Secondary prevention, in the form of screening have been found effective for cervical cancer and to a lesser extent for breast cancer among women over the age of 50^{vi}. Although efforts are underway to develop screening methods for stomach and prostate cancer, results are still controversial. Data shows that at least 80 per cent of patients in developing countries are incurable at the time of diagnosis.^{vii} It follows, that the increase in the caseload will result in an increase demand

for tertiary care that not all countries can afford. Efforts for cancer prevention and control should, therefore, include all the spectrum of the disease.



Cancer Control Programs

Currently, the most comprehensive and effective approach to the prevention and control of cancer is through the development of National Cancer Control Programs (NCCD), which considers cancer in the context of health priorities, incorporate evidence based interventions and availability of resources. The World Health Organization has published guidelines for NCCP covering prevention, early detection, treatment, rehabilitation and palliative care^{viii}. A National Cancer Control Program should be regarded as a process to establish an integrated national or regional program, with intermediate objectives and clear and measurable goals in order to adequately utilize the economic resources, setting the limits of the program in function of the social, medical and political characteristics of each country^{ix}.

In a short inquiry, conducted by HCN, six Latin American countries reported having a NCCP according to WHO guidelines: Chile, Costa Rica, Cuba, Honduras, Paraguay and Venezuela. PAHO has formally conducted a program evaluation in two of them: Cuba and Costa Rica^{x xi}, only in Cuba all the elements of a NCCP were considered.

In Costa Rica as a consequence of the report the government appointed a Commission to elaborate a proposal on a NCCP, the draft report is still under discussion. Seven countries, said to offer palliative care and cancer pain relief treatment to advanced cancer patients through public institutions (Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Mexico and Paraguay). In several countries there are private initiatives that offer palliative care and cancer pain relief to advanced cancer patients (Bolivia, Chile, Colombia, Ecuador, Guatemala, Honduras, Nicaragua, Mexico, and Venezuela).

National Cancer Control Programs in Spanish speaking countries of the Region (1997)

Country	Has the country adopted a NCCP according to the WHO Guidelines?	Does the NCCP include Palliative Care and Cancer Pain Relief?	Are there other private or public Palliative Care and Cancer Pain Relief Initiatives?
Argentina	Yes	No	Yes
Bolivia	Partially	No	Yes
Chile	Yes	Yes	Yes
Colombia	No	Yes	Yes
Costa Rica	Yes	Yes	No
Cuba	Yes	Yes	No
Dominican Republic	No	Yes	No
Ecuador	No	No	Yes
Guatemala	No	No	Yes
Honduras	Yes	No	Yes
Nicaragua	No	No	Yes
Mexico	No	Yes	Yes
Panama	Partially	No	No
Paraguay	Yes	Yes	No
Peru	No	In project	No
Salvador	No	No	No
Uruguay	Partially	No	No
Venezuela	Yes	No	Yes

The extent to which these initiatives cover all the persons with cancer it is not known, however, based on the reports from Costa Rica and Cuba, two countries with a widely extended health system, palliative care services are offered mostly in urban areas and to those with higher level of education. The accessibility to palliative care is measured internationally through the use of morphine, as a surrogate for pain relief. The situation in

Latin America and the Caribbean is less than desirable, according to the data provided by the International Narcotic Control Board (INCB).

Total consumption of Morphine in selected countries from the Region^{xii}

(Expressed as number of daily defined doses per million population per day)

Country	1978-82	1983-87	Country	1978-82	1983-87
Canada	323	885	Dominica	12	11
USA	187	404	Nicaragua	17	7
Bermuda	435	328	Costa Rica	4	4
Barbados	27	74	Guatemala	4	4
Uruguay	126	59	Venezuela	6	4
Bahamas	11	41	Dominican Republic	1	2
Cuba	20	29	Mexico	4	2
Colombia	25	25	Brazil	-	1
Trinidad and Tobago	8	24	Ecuador	7	1
Argentina	5	15	Bolivia	-	-
Jamaica	13	12	El Salvador	1	-
Chile	13	11	Honduras	1	-

In most Latin American and Caribbean countries, almost all cancer treatment is performed in tertiary care hospitals. Surgery alone is used mostly for cancers of the breast, cervix, colorectum and oral cavity. In early stages the possibilities of cure are remarkably high. Cancer in more advance stages require radiotherapy and/or chemotherapy. The latter offers a chance of cure for leukemia and certain lymphomas. Few studies have been conducted on survival of different types of cancers in Latin America and the Caribbean.

Information on direct and indirect costs for cancer is almost nonexistent in Latin America and the Caribbean. Estimates for lower middle income countries have been produced, based on direct costs of tertiary care centers in the US. The table below shows the cost of treatment expressed as GNP per capita relative to the cost in the US (base 100%) and the cost per year of life gained from tertiary -level treatment in a hypothetical lower- middle income countries, of a GNP per capita of US\$ 1,500. The assumption of this model is that all persons with cancer are diagnosed and treated and the system has no major inefficiencies, which is something that can be challenged for most Latin American and Caribbean countries, nonetheless is the best data available so far.

Cost per case treated as percent of GNPN and cost per year of life gained from tertiary level treatment for major cancer sites.

Site	Cost per case treated percent of GNPN		Cost per year of life gained from tertiary level treatment in lower middle income country (3% discount rate)
	High income country	Lower-middle income country	
Mouth/pharynx	79	243	55
Esophagus	115	709	4,056
Stomach	112	687	2,826
Colon/rectum	110	336	154
Liver	118	727	4,083
Lung	127	782	1,354
Breast	67	206	33
Cervix	57	174	90
Leukemia	114	700	---
Average	104	641	

Source: Barnum H. And Greenberg, Cancers. pp 529-559. In Janison DT, Moskey WH, Measham AR, Bobadilla JL. Disease Control Priorities in Developing Countries, Oxford University Press, 1993.

Although data must be interpreted cautiously, this table shows that the cost of treatment represents a higher burden in terms of GNP per capita, for lower-middle income countries, when compared to a high-income country. It follows, that from a public policy perspective and from a technical stand, there is a need to find cost-effective options, for countries that do not have the resources but are and will be facing an increasing demand for service from persons with cancer.

Case Report

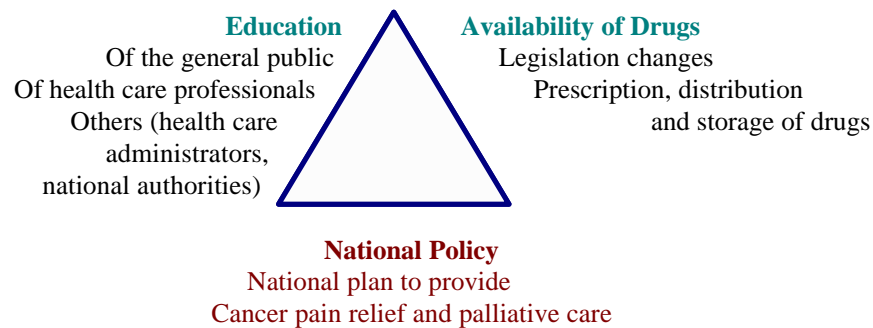
José, a 63-year-old man was admitted in 1991 to a palliative care program in Cali, Colombia. Upon admission, a man for whom he had worked for the last five years accompanied him. This man informed the health professionals that Jose lived by himself in a hog barn, had been diagnosed with laryngeal carcinoma in 1988 and undergone a radical laryngectomy with permanent tracheostomy three months later. In the last six months he experienced progressive weight loss, asthenia, and pain in the head and neck region that did not allow him to move his head forcing Jose to walk in a bent forward position. These symptoms made him seek treatment in the emergency room at the State University Hospital repeatedly, where he was given injections of anti-inflammatory drugs and sent home, after being told that nothing else could be done for him. Jose was unable to communicate verbally only by mimicking with his mouth, and because of his low level of education, also unable to write. Upon admission to the palliative care program, Jose was provided with adequate hygiene, meals and assigned a bed in the ward. The initial assessment identified severe pain in the neck region, insomnia, diarrhea, and dyspnea as the main symptoms. Jose was given different medications to treat these symptoms, including codeine as a pain reliever. In the following two days he refused to complain of any symptoms and showed extreme gratefulness to all the staff members, but nurses and physicians observed that he was continuously adopting an antalgic position and that swallowing was still painful. When questioned, Jose assured the staff members nothing was wrong. After conversations with his friend, it was learned that Jose refused to complain because he was afraid that if he did so, he might be discharged from the palliative care program to return to the previous situation in which he was forced to go to the hospital emergency room whenever he required medical treatment. After this, Jose was given morphine on regular doses for pain control, lidocaine before each meal and reassured that he would continue to be under the care of the palliative care program. Two days after, he was able to walk on a straight upward position and to feed himself. He was discharged from the institution with scheduled weekly follow up visits. The disease continued to progress, but the pain and symptoms were kept under control until he died, three months later.

Introducing Palliative Care

Palliative care is often ignored and is an option that sometimes is made available to the patient too late in the course of the disease. Instead, palliative care needs to be seen as an integral part of cancer control, emphasizing the need to alleviate cancer pain and suffering through education, drug availability and social support. Five countries in the Region of the Americas, Canada, Chile, Mexico, Colombia, and Cuba ^{xiii}, have recognized the importance of pain relief and palliative care and have made explicit the need for a public health approach to the issue.

Strategy for Palliative Care

At the base of a strategy, there should be a national policy, whereby a plan of action is derived. This may very well be projected as a phased introduction of the program, beginning at the major cancer centers in order to build technical capacity, but at the same time it should be decentralized to provincial hospitals and community health centers. The legislation and regulation that enhance the availability of drugs for palliative care, provide the framework for the operationalization of the national policy. The education and information to both the public and health professionals are instrumental to the implementation^{xiv}.



Components of palliative care

As an integrated approach to disease management at the end-of-life, palliative care involves a number of dimensions that include but go beyond clinical care. The first step is the control of pain and other symptoms, that can be managed at home or at the first level of care. This requires the availability of opioids and other drugs, enhance clinical skills for the management of this type of patient among health professionals, as well as education to the patient and the immediate family on the course of the disease and how to care for the person with the illness. Currently, because of lack of information and apprehension to assist the terminally ill, most of these patient are unnecessarily hospitalized or resort to frequent visits to the emergency room. The second dimension relates to the psycho-social support to the patient and their family in the process of deterioration and death. This is best handle at the community level where there may be a number of mechanisms both spiritual and for specific health care needs that could help the family cope with this process. In caring for an ill person the family may not only experience the emotional stress, but also loss of income or inability to work. Lastly, consideration should be given to general ethical principles of Autonomy, Beneficence, Justice and Non-maleficence, which should guide program development and decision making.

Pain Management

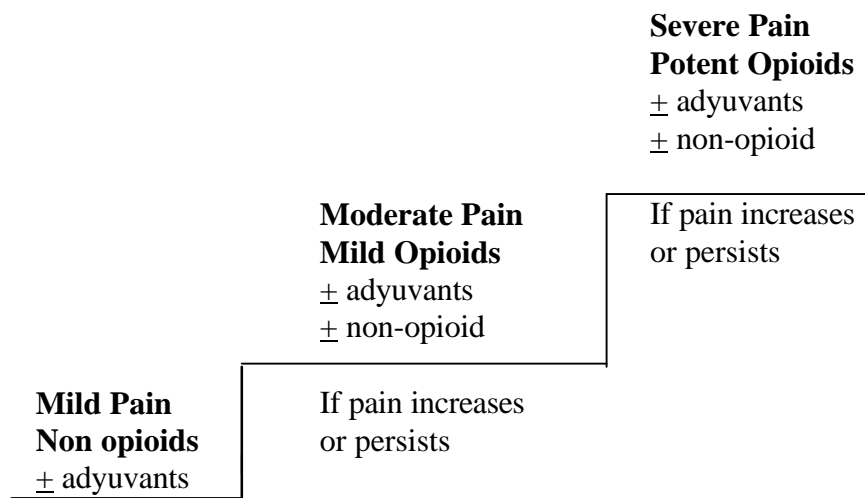
Cancer pain occurs in about one third of patients receiving anticancer therapy, while in advanced disease patients, it is more than two thirds of patients who experience pain. It is estimated that 25 per cent of all cancer patients throughout the world die

without relief from severe pain.^{xv} Many patients with advanced cancer and moderate to severe pain are not given sufficient analgesic medication to control their suffering.

The intensity and type of pain increases as the disease progresses, with significant variation according to the primary site of the tumor^{xvi}. Pain may be caused by cancer itself (nerve compression, nerve lesion, tumor invasion to visceral, soft, or bone tissue); related to cancer (e.g. muscle spasm, constipation, skin ulcers); related to cancer treatment (e.g. skin burns due to radiotherapy, nerve lesions or stomatitis due to chemotherapy); or caused by a concurrent disorder (e.g. arthritis, spondylosis). Psychological factors have been demonstrated to also play an important role in the presence of pain. A sense of hopelessness, depression, or anxiety adds to the total suffering of patients and increases the pain intensity^{xvii}. Although cancer pain may be thought of as a crisis that emerges in advanced stages of the disease, it may occur at any time during the course of the illness and cause suffering, loss of control, and impaired quality of life for the person with cancer. Suffering denotes an extended sense of threat to self-image and life and a perceived lack of options for coping with symptoms and problems caused by cancer. Personal control is undermined when cancer is diagnosed, and is further reduced by ongoing pain, treatment procedures, hospitalization and surgery, and the quality of life and patient's satisfaction with treatment is significantly worse than that of cancer patients without pain.

In 1982, a WHO experts panel established a relatively inexpensive, easily applicable approach for pain treatment, known as the *Three-step Analgesic Ladder*,^{xviii} this approach has become accepted worldwide and is being implemented in several countries. The first step is the use of acetaminophen, aspirin, or other non-steroidal anti-inflammatory drug (NSAID) for mild to moderate pain. Adjuvant drugs may be used at any time to enhance analgesic efficacy for specific types of pain. When pain increases or persists, a mild opioid such as codeine or hydrocodone should be added to the NSAID. When higher doses are needed and the maximum therapeutic dose has been reached, they should be replaced with potent opioids such as morphine, hydromorphone or fentanyl.

The WHO Three Step Analgesic Ladder



The analgesic ladder is based on the systematic use of opioid and non-opioid analgesics given by the clock, and not on the “as needed” basis. Therefore, the availability of analgesics such as codeine and morphine is essential in order to achieve adequate relief. There are still 51 countries for, which there is not registered morphine consumption in the world, nine of which are in the Americas.^{xix}

International Drug Control Treaties

The international drug control treaties seek to achieve a balance between the need for narcotic drugs and psychotropic substances for medical and scientific purposes and the need to prevent their abuse or misuse^{xx}. The production or manufacture of such drugs and substances as well as their distribution and use, must take place in accordance with control measures designed to achieve the objectives of the Single Convention of Narcotic Drugs of 1961 (1961 Convention),^{xxi} the Convention on Psychotropic Substances of 1971 (1971 Convention),^{xxii} and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988 Convention).^{xxiii}

International Narcotics Control Board (INCB)

The International Narcotics Control Board (INCB) is the independent and quasi-judicial control organ for the implementation of the United Nations Drug Conventions.^{xxiv} The INCB is independent of Governments as well as of the United Nations: the 13 members that make up the Board serve in their personal capacity. They are appointed by the United Nations Economic and Social Council (ECOSOC). Three members are selected from a list of candidates nominated by WHO and ten from a list nominated by member countries.

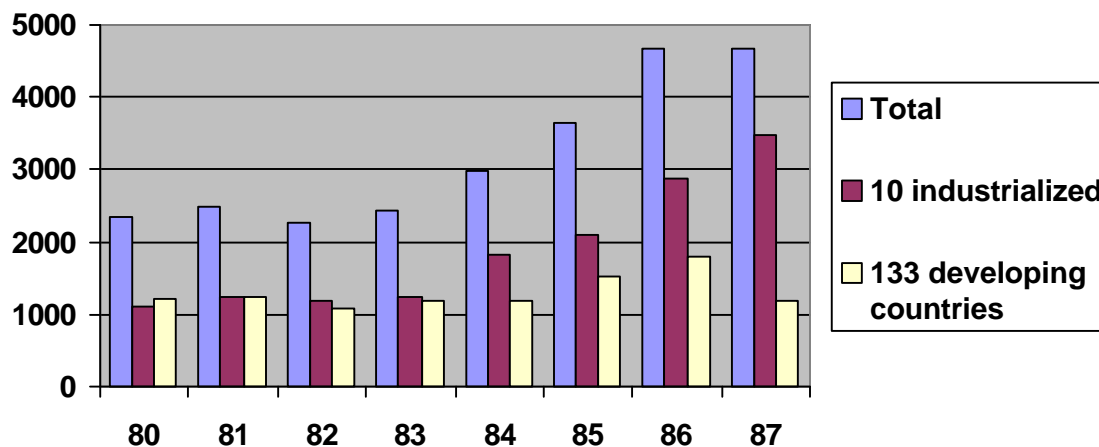
The international system for the control of the licit movement of narcotic drugs under the 1961 Convention functions in a satisfactory manner and generally does not constitute a source for illicit traffic.^{xxv} In member countries, demand of opioids for medical and scientific needs, is expected not to exceed the amount of opioid supply estimated or established by the Board in cooperation with WHO^{xxvi xxvii} Based on its activities, INCB publishes an annual report^{xxviii xxix xxx} that is submitted to ECOSOC, which provides a survey of the drug situation in various parts of the world. This is supplemented by technical reports containing an analysis of the production and consumption of opioid medications, making recommendations to member countries, professionals, educators and legislators aim at minimizing the impediments to ensure adequate availability of opioids for the treatment and management of severe pain.

Opioids Consumption

Morphine consumption is a broad indicator of progress to improve cancer pain relief^{xxx}, and can be constructed with data that are reported to the INCB by member countries. Consumption data may include amounts which are used to manufacture combination products that contain a small amount of morphine which are subject to less restrictive controls. On the other hand, it may not completely indicate the extent to which opioids are used for the treatment of severer pain, as other opioids such as methadone, hydromorphone, levorphanol, and pethidine are also used to relieve cancer pain.

Increases in morphine consumption over the past ten years have occurred mainly in 10 countries (Denmark, United Kingdom, Iceland, Canada, Australia, Norway, Sweden, USA, Switzerland, and Finland).^{xxxii} Total consumption of morphine in these ten countries accounts for 75% global use; the remaining 25% is consumed in the other 133 countries for which data are available. Consumption reported by Latin America and the Caribbean accounts for less than 1% of the global morphine consumption for medical and scientific purposes^{xxxiii}.

Global Morphine Consumption (in Kg.)



Consumption per capita for 1993 in selected countries of the Americas^{xxxiv}

Country	mg/per capita	Country	Mg/per capita
Canada	28.41	Paraguay	0.4
United States	20.8	Cuba	0.275
Costa Rica	0.625	Barbados	0.005
Argentina	0.588	Bolivia	0.005
Colombia	0.516	Ecuador	0.005
Chile	0.438	Mexico	0.005

In a review commissioned by ECOSOC the INCB and WHO have jointly identified the following obstacles to availability of morphine and codeine:^{xxxv}

- Misinterpretation of the Single Convention on Narcotic Drugs, 1961, by drug regulatory authorities;
- Legislative, regulatory and administrative impediments that exist in various countries and that lead to the underutilization of opioids;
- Medical, nursing and pharmacy practices;
- Perception and knowledge of health care workers about the role of opioid analgesics in treatment, the availability and use of alternative treatments;
- Shortage of health care workers and facilities (including the infrastructure for opioid distribution);
- Financial constraints of drug costs, both to the country and to the individual patient;
- Structural constraints and the difficulties encountered by pharmaceutical companies to introduce opioids into a market;
- Constraints on availability stemming from governmental action to combat drug abuse.

Opioids Costs

The most recent progress report from the Latin American Palliative Care and Pain Relief Meeting shows a decrease in the cost of some commercial opioid presentations.^{xxxvi} For example, the cost of immediate release morphine in Argentina and Mexico has decreased 10 times as compared to 1994. In addition, new and less expensive presentations are available in Brazil, Costa Rica, Argentina, Chile and Colombia. However, there are countries in which the costs of some presentations are still too high, the reasons stated are: 1) Pharmaceutical companies have to pay large overhead costs for the import and distribution of the drugs, which are then charged to the patient; 2) In some like countries such as Venezuela, morphine powder is not imported, and the only products available are expensive presentations of opioids analgesics and 3) the small quantities of drugs, which reach the rural areas, are sometimes charged the extra costs of the distribution process. In Brazil, patients in rural areas may be charged an extra 15-20% of the original price of morphine analgesics found in major cities.

Barriers to Opioids Use

Legislative restrictions vary greatly from country to country. Governments are responsible for applying the recommendations from the International Treaties and national control authorities are to enact laws and enforcement measures to prevent illicit production, manufacture, and use of narcotic drugs. Most of the legislative barriers that impede the adequate use of opioids are the result of overregulation in the interpretation of the treaties.

Restrictions may arise from barriers found in the Legislation, in the Regulations, and/or at the administrative level. Analyses of the Colombian and the Mexican legislation have shown different barriers at these levels,^{xxxvii xxxviii} such as misuse of terms and definitions concerning opioid use, failure to acknowledge in the law the benefits of adequate pain treatment, lack of legal responsibility and accountability for the parties involved in the process of importation, manufacturing, and distribution; and the establishment of time, dosage, and potency limits for opioid prescriptions.

Barriers in Legislation (Mexico)

General Health Law, Article 241:

The prescription of narcotics will be done in special forms, edited, authorized, and distributed by the Secretary of Health under the following conditions:

- a. In special prescription forms by authorized physicians according to the Article 240 of this Law, for patients that do not require them for a time limit greater than five days, and
- b. By special permission to the respective health professional, for the treatment of patients who may require them for more than five days.

Administrative Barriers (Mexico)

Instructions in the Special Prescription Form:

All injectable opioids may be prescribed for a maximum of 24 hours. Oral codeine and dionine may be prescribed for a maximum of 72 hours, as long as it specified as such in the prescription.

Barriers in Resolutions (Colombia)

Resolution 6980, Article 51:

The total prescribed amount of controlled medications will be done according to the following guidelines:

- a. Narcotic Analgesics: Up to the dosage required amount for 10 days.
- b. Moderately Narcotic Analgesics: Up to the dosage required for 30 days.

In addition, to the already low consumption in relation to the number of cancer cases, and in spite of codeine and morphine being included in the WHO Essential Drugs List^{xxxix}, there is still one country in the Americas that does not include opioids analgesics in their list of essential drugs^{xl} and another country that this year did not make the appropriate request to import morphine to the INCB.

Ethical Aspects

As with any public health program, palliative care needs to be evaluated against basic ethical principles. The principles of autonomy and beneficence must be addressed at the individual level^{xli}. Autonomy refers to the respect for the person's capacity to decide between options and benefit to the ethical obligation to increase the benefits to the maximum and reduce the potential damages to the minimum, while considering that we are addressing a concept of "good" which is defined with the patient. Some of the issues that health personnel are confronted with at the individual level are:

- Life-prolonging treatments may be contraindicated if they are the source of more suffering than benefit. Medicine reaches a limit when it can only offer an extension of function, which may be perceived as a prolongation of dying rather than sustaining life—which in turn, poses the need to address the issue of quality of life.
- Some health care professionals find it easier to withhold life-prolonging treatments than to discontinue such treatments once they have been started.
- Life is not an absolute good and death is not an absolute evil. Technological aided efforts to extend life may interfere with higher personal values.

At the collective level, public health decision makers are faced with questions that relate to justice and non-maleficence:

- Do all persons with cancer or a terminal disease have the same accessibility to palliative care?
- Is home-care the most appropriate care for the terminally ill? Aren't we imposing on a family?
- Should there be technologically advanced facilities for all persons with cancer in the hope that there is a slight possibility of cure?
- Should we allocate public health resources to the persons that already have cancer?
- What happens with the persons that are not diagnosed and to whom care is never provided? Who are those persons?
- Who bears the burden for the terminally ill in a situation of limited resources? What are the consequences?

Conclusion

Palliative care for persons with cancer and other chronic diseases is yet to be addressed with a public health perspective in Latin America and the Caribbean. From the health services, the problem can be approached by increasing the capacity of health personnel, particularly nurses and primary health care physicians, to manage the chronically and terminally ill patient at the first level of care. From the society at large there is an increasing need to develop social and medical support schemes that can assist families to care for the terminally ill in the best way, this also brings about the basic human need which is to die with dignity surrounded by loved ones.

The road to develop a program, implies actions at the policy level, particularly providing information to decision makers as to what can be achieved with this type of program, which in a sense are largely unknown. Additionally, demonstration projects will provide information on the do's and don'ts to implement such a program. PAHO can play an important role in addressing this issue, which up until now, has been handled as an exclusively medical problem, thus limited to individual solutions, and position it in a public health context, which would be expected to bring about broad solutions to which all persons would have equal access.

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