The INSIDE STORY®

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What's Inside

THE IMPACT OF CHRONIC PAIN IS ALL AROUND US... INCLUDING THE WORKPLACE

PAGE 2

WHAT'S UP...

Federal committee report recommends national pharmacare

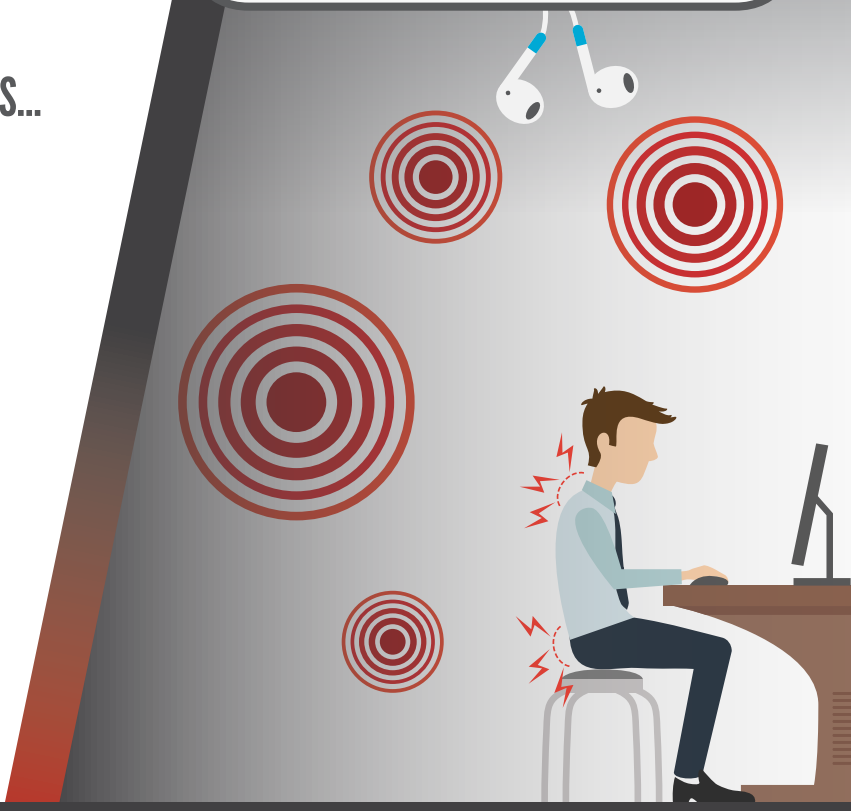
Report recommends changes to pan-Canadian health organizations

PAGE 9

AND NOW FOR SOMETHING...

Be sure to check out the companion podcast with guests Tahir Janmohamed, the president and CEO of Managing Life, and GSC's own Peter Gove.

COMPLETELY INDIFFERENT



THE IMPACT OF CHRONIC PAIN IS ALL AROUND US...

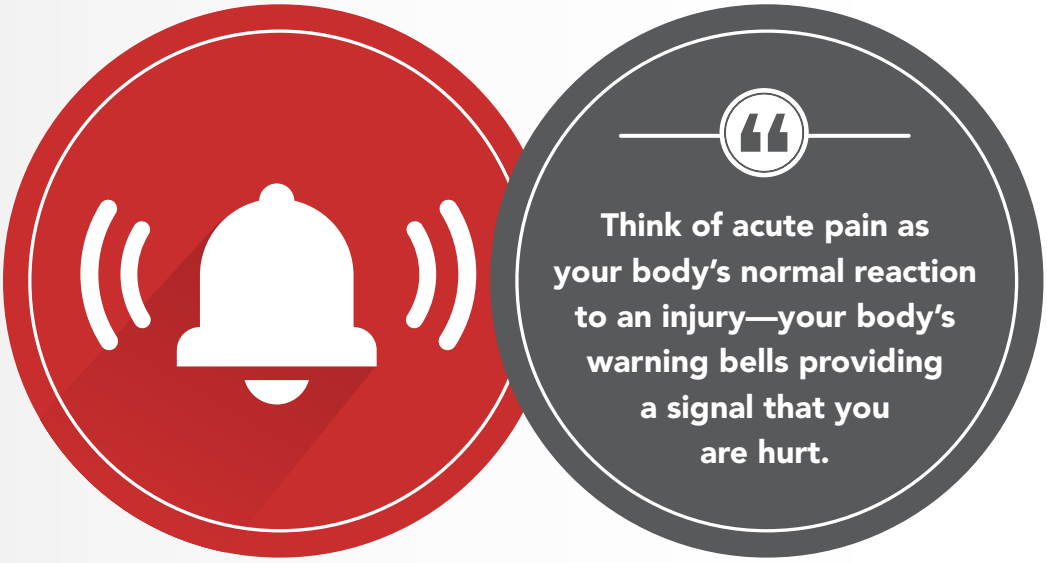
INCLUDING THE WORKPLACE

Why is it that someone can have a major physical injury, illness, or surgery and experience little or no pain, whereas, someone else may have severe pain—*that lasts*—without being able to identify any physical damage or cause?

Herein lies the complexity of chronic pain. It is long-term, non-acute pain that is highly individualized and very difficult to treat. However, a variety of pain management options continue to emerge in the scientific evidence illustrating that because your plan members' chronic pain takes on many forms, so too should its treatment. But first, here's a chronic pain refresher…

CHRONIC PAIN CAN BE THE RESULT OF:

- → **Underlying disease or medical condition:** For example, shingles may have persistent painful flare-ups even after the disease has been cured, and in some diseases—like many types of cancer and often with AIDS—chronic pain may worsen as the disease progresses.
- → **Inflammation:** For example, with rheumatoid arthritis and gout, inflammatory pain persists as long as inflammation exists in the joints.
- → **Medical treatment:** For example, if the normal kind of immediate acute pain after surgery evolves into chronic pain or if nerve damage occurs during the surgery.
- → **Injury:** For example, "phantom limb" or "phantom tooth" is when pain persists after a limb is amputated or a tooth is extracted.
- → **Neuropathic pain:** For example, diseases like diabetes or injuries like stroke or spinal cord damage can lead to a disease of the peripheral or central nervous system due to damage in the nerves, spinal cord, or brain. However, in some cases neuropathic pain may not have an identifiable cause.
- → **Unknown causes:** For example, people with chronic headaches, fibromyalgia, irritable bowel syndrome, and temporomandibular disorders often have chronic pain without a defined cause or injury.



Pain as warning bells

A well-known definition of pain is "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage."[1] Accordingly, pain can result from damage to tissues like muscles, ligaments, nerves, tendons, and blood vessels, as well as when a bone breaks and its surrounding tissues are injured. Pain is broadly categorized into acute and chronic pain.

Acute pain is defined as "pain that comes on quickly, can be severe, but lasts a relatively short time."[2] Think of banging your "funny bone;" that pain lasts seconds or a few minutes. So acute pain can be clearly linked to a specific event, injury, or illness, and it doesn't last very long because the majority of injuries will heal normally within three months at the most. You can think of acute pain as your body's normal reaction to an injury—your body's warning bells providing a signal that you are hurt.

People can usually handle a wide range of acute pain on their own by, for example, taking over-the-counter medications or a short course of a stronger analgesic. Some will avoid meds and "tough it out." As the underlying cause of the acute pain subsides, so too usually does the pain itself.

Chronic pain, on the other hand, is defined as: "Ongoing or recurrent pain lasting beyond the usual course of acute illness or injury or, generally, more than three to six months and adversely affecting the individual's well-being."[3] A simpler definition for chronic or persistent pain is "pain that continues when it should not." Although chronic pain is ongoing, it may be intermittent throughout the day and night or it may be persistent in its intensity.

One theory is that when the original injury or cause of acute pain has healed—but pain persists and becomes chronic—it is an abnormal "processing" of pain. In keeping with this theory, chronic pain is like warning bells that are still going off when there is no need to still signal harm.[4]

Because pain can endure long after the illness or injury that caused its initial onset has been treated or healed—or not have a clearly identified root cause—many physicians and researchers now consider chronic pain its own condition, not just a symptom of another prognosis.[5] Hence why it has entered our lexicon to such a degree.

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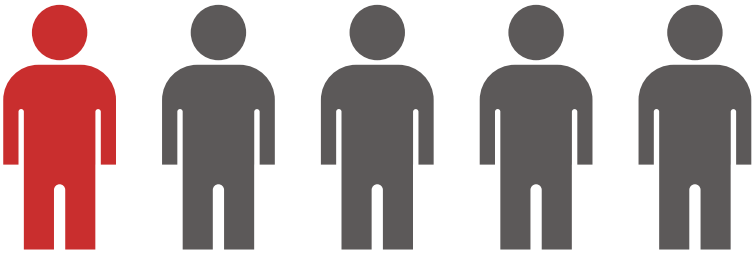
ALMOST ONE IN FIVE CANADIAN ADULTS HAVE CHRONIC PAIN



DIFFERENT COUNTRIES, SIMILAR STUDY RESULTS

Studies across various countries worldwide confirm that chronic pain negatively affects workplace productivity. For example:

- In Canada, of people waiting for care at pain clinics, 72% report that pain interferes with their normal work.[6]
- With the lower back identified as one of the most common locations for chronic pain, findings in the United States conclude that, specifically in the 45- to 65-year-old age group, lower back pain is one of the most frequently cited medical reasons for work loss.[7]
- In Spain, research indicates that 24.4% of individuals suffering from chronic pain requested sick leave in the previous year, and 12% left or lost their job because of chronic pain. In addition, between 43% and 78% of fibromyalgia patients were on sick leave with total disability status ranging between 6.7% and 30%.[8]

High prevalence of chronic pain in Canada

Research variables like differences in population samples, varying definitions of chronic pain, and diverse research methods, makes a definitive identification of the incidence of chronic pain in Canada difficult. However, consensus is that it's high: a finding from one of Canada's most recent research studies indicates that almost one in five Canadian adults have chronic pain.[9]

In addition, almost half of those with chronic pain reported suffering from it for more than 10 years and rated the intensity in the very severe range. Participants identified the lower back as the most common site of chronic pain, and if a cause was identified, the largest causes were arthritic pain, back and spine pain, and pain due to trauma. Given that this study used a representative sample of adults from across Canada, it's concerning to consider all of those suffering from chronic pain—including your plan members.[10]

Of course, the high incidence of chronic pain means that it's definitely a reality in today's workplace. Although research is limited regarding the impact specifically of chronic pain on Canadian workplaces, international findings include that absenteeism, presenteeism, early retirement, and disability related to chronic pain present a burden at least as great as conditions that are traditionally prioritized as public health concerns.[11] For example, chronic pain is associated with the worst quality of life as compared with other chronic diseases such as chronic lung or heart disease.[12]

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Consequences are far reaching

Adding to poor quality of life is that chronic pain itself may cause other issues. For instance, uncontrolled pain often compromises immune function and compromises healing.[13] In addition, although it isn't possible to definitely predict who may suffer from chronic pain, research indicates that people are more likely to develop chronic pain during or after times of stress or unhappiness.[14]

And the reverse is also the case; not surprisingly, many people with chronic pain become depressed or experience other mental health problems. For example, more than half of people waiting for care at Canadian pain clinics have severe levels of depression.[15] A recent GSC Health Study analysis showed that pain medication was the most common secondary medication for those using antidepressants. In fact, research indicates that people living with pain have double the risk of suicide as compared with people without chronic pain.[16]

Clearly, the effects of chronic pain are far reaching. However, a range of approaches is emerging in the scientific evidence that should help chronic pain sufferers improve their quality of life, including staying on the job and continuing to be productive. This is especially important as it is well documented in the research that longer absenteeism is associated with poor recovery, including no quicker return to work and no increased health benefits.[17] And this includes when taking opioids: a recent study of workers with low-back injuries reveals those who receive longer-term prescriptions for opioids take significantly longer to return to work than those who are not taking opioids.[18]

Biopsychosocial model of pain

The emerging research about approaches to chronic pain is based on what is known as a biopsychosocial model of pain. This model suggests that all areas of a person's life—biological, psychological, and social factors—all interact to impact pain perception. Accordingly, chronic pain isn't just about body tissue damage but rather is associated with *actual or perceived* bodily tissue damage *combined with* cognitive, sensory, emotional, and social components.

For example, people with chronic pain can get caught in a downward spiral—what is often referred to as the fear-avoidance cycle. They are fearful of re-injury or making the pain worse, so they avoid movement and activities, which may include work. Inactivity can lead to what is known as deconditioning which includes decreased strength and mobility. It can also lead to deteriorating mental health, such as anxiety and depression as fear increases and avoidance leads to increased isolation. Some chronic pain sufferers end up completely fixated on their pain, and their identity revolves around that pain.

Interestingly, in terms of risk factors that make it more likely to transition from acute pain to chronic pain and long-term disability are factors that illustrate the biopsychosocial model of pain. For instance, the severity of the injury and physical job demands don't seem to contribute as much as other factors like the existence of other co-occurring physical or mental conditions, substance abuse, lack of social support, job dissatisfaction, and presence of the fear-avoidance cycle.[19]

The biopsychosocial model of pain conveys that chronic pain persists due to *multiple interrelated factors*—and now the scientific evidence continues to emerge recommending *multiple interrelated approaches* to treat and manage chronic pain. First let's start with drugs…

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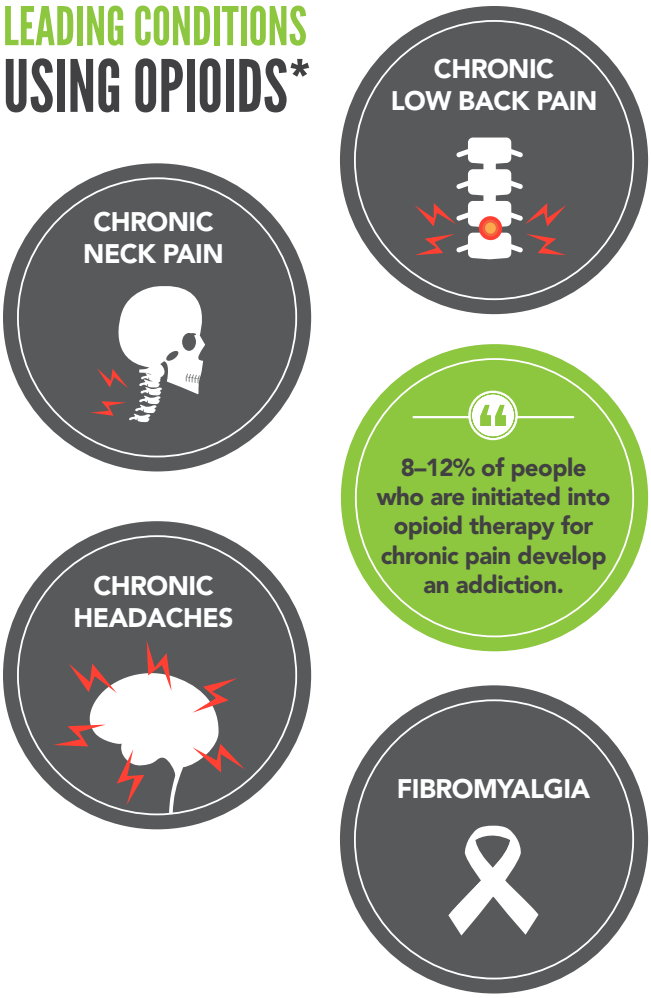
LEADING CONDITIONS USING OPIOIDS*



*For more than six months for chronic non-cancer pain

EXAMPLES OF CLINICAL GUIDELINES

The shift toward non-pharmacological approaches to chronic pain is reflected in:

- → Canada's new opioid prescribing guideline that recommends optimizing evidence-based alternatives prior to considering opioids.
- → Canada's National Pain Centre's recommendations that advocate for alternatives to opioids when considering therapy for patients with chronic non-cancer pain.

The pain/pill connection

Although there definitely isn't one magic pill that will help relieve pain for all people, there are several pharmaceutical choices for treating chronic pain. Accordingly, before deciding which drug(s) are most appropriate, it's essential to have a proper diagnosis. This helps ensure that the patient is on the drug for the right purpose and is being properly managed by their doctor who is ensuring their patient is getting a benefit from the drug that outweighs the risks.

For example, some people with arthritis find anti-inflammatories helpful as a pain management tool. There are also combination treatments; for instance, some chronic pain sufferers experience more relief when an antidepressant is added as an adjunct treatment. Other types of medications like gabapentinoids and nerve blocks may also be helpful.

And then there are opioids…

Research indicates that opioids can be beneficial for relief of *acute* pain—like wounds and broken bones—and in managing pain for people with cancer and those in palliative care.[20] However, as you may recall from the November 2016 edition of *The Inside Story*, opioid prescribing was encouraged in the early 1990s for pain management and became associated with wider use for conditions other than injury, surgery, or cancer-related pain. For example, a Canadian study of patients who had been using opioids for more than six months for chronic non-cancer pain found the leading conditions being treated were chronic low back pain, chronic neck pain, chronic headaches, and fibromyalgia.[21]

These broad prescribing practices greatly contributed to today's opioid crisis as the potential for long-term opioid use increases after as few as three to five days of taking opioids.[22] In fact, research suggests that 8-12% of people who are initiated into opioid therapy for chronic pain develop an addiction. [23]

It is now well-documented that opioids only treat pain as a symptom; they mask or limit pain but do not address the underlying causes of pain and can make treatment even more difficult.[24] Accordingly, it's important that in most cases, plan members with chronic pain steer clear of opioids to begin with. They need to learn about the pain management approaches that are emerging in the scientific evidence—not necessarily pharmacological approaches.

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As always, follow the scientific evidence

A variety of non-pharmacological approaches has been shown to effectively and safely help people with chronic pain. For example, a review of clinical practice guidelines for people with low back pain without a known cause (known as non-specific low back pain), reveals that various guidelines from around the globe now recommend non-pharmacological interventions as first-line treatment, only recommending pharmacological treatment following inadequate response to non-pharmacological interventions.[25] And contrary to the "bed rest is best" theory of the past, the guidelines recommend that people with low back pain avoid bed rest, and instead stay active and continue with their usual activities—including work. Exercise programs should be encouraged, as well as other non-pharmacological approaches like physiotherapy, as well as psychological therapies like cognitive behavioural therapy and mindfulness programs.[26]

This type of evidence is emerging across a wide range of types of chronic pain. Obviously, to make a difference in plan member health and keep them at work, it's important for them to know about the non-pharmacological approaches emerging in the research. And it turns out that it is especially important that they are "in the know" because their doctors may not be. Although the ideal is that treatment for chronic pain is in line with the best available evidence, some physicians are still relying solely on pharmacological treatments. And many still recommend outdated advice that focuses on limiting the activities of daily life—including avoiding exercise and staying away from work.[28]

What's with the disconnect? A wide range of factors are likely at play. At a fundamental level, there is the issue of the complexity of chronic pain; traditionally physicians are trained on a medical model that focuses on physiology and what was conventionally—and conveniently—at hand: medications.

The reliance on prescribing may also be influenced by benefits coverage. All provincial and territorial drug plans and most extended health benefits programs cover opioids. By contrast, public plans typically do not fund non-pharmacological interventions and private plans may not provide sufficiently generous coverage.[29] And as we've seen with other "invisible conditions" like mental health, barriers to non-pharmacological options can include access and cost barriers including long waiting lists for mental health professionals and fees that are unaffordable within coverage maximums.

NON-PHARMACOLOGICAL APPROACHES IN ACTION

Evidence is building for non-pharmacological approaches including:

- → Education
- → Maintaining normal activities
- → Exercise including aqua fitness, yoga, and tai chi
- → Physiotherapy
- → Stretching
- → Chiropractic services
- → Nutrition counselling
- → Acupuncture
- → Stress management
- → Cognitive behavioural therapy
- → Mindfulness programs

For example, **physiotherapy and exercise** have been shown to reduce pain by helping increase movement, range of motion, and muscle strength. And **occupational therapy** can help people learn how to safely continue activities of daily living even when they feel pain. And as always, following a **healthy diet** can only help; for instance, people with chronic back or knee pain who lose weight often experience some pain relief. **Cognitive behavioural therapy** can be helpful in addressing some of the psychological issues that often accompany pain such as fear of re-injury and fear of stopping painkillers. Clinical trials have also shown that **mindfulness meditation** can reduce chronic pain by 57% with some experienced meditators seeing a reduction of over 90%.[27]

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MANAGE MY PAIN

NEW APP

To help plan members take control and take action, we'll soon be piloting a new app called *Manage My Pain*. It helps people take control through the ability to easily and effectively track their pain and analyze it (think Fitbit for pain management). Building on this, the user can also create reports, so they can take action by sharing the data with their doctor. Intrigued? Listen to GSC's latest podcast where four-time podcaster, GSC's very own Peter Gove, innovation leader, health management, and Tahir Janmohamed, the president and CEO of the app's manufacturer, Managing Life, are featured guests.

Chronic pain may be invisible… but chronic pain patients need not be

Although the scientific evidence is building regarding the benefits of non-pharmacological approaches, more evidence and more exposure to the evidence is necessary. So spread the word to your plan members! Encourage them to work with their doctor to receive a comprehensive and compassionate approach—one that doesn't rely solely on medication, but instead integrates a combination of physical, cognitive, and emotional therapies. No more one-size-fits-all pharmacological treatment.

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What's UP...

FEDERAL COMMITTEE REPORT RECOMMENDS NATIONAL PHARMACARE

The House of Commons' Standing Committee on Health recently released their report called *Pharmacare Now: Prescription Medicine Coverage for All Canadians*. It recommends the creation of a universal single-payor public prescription drug coverage program for all Canadians. To accomplish this the report recommends developing a national drug formulary, expanding the Canada Health Act to include prescription drugs dispensed outside of hospitals as an insured service, and sharing costs among federal, provincial, and territorial governments.

The report is the result of two years of committee hearings where two possible options for pharmacare were assessed. The first option—the one they selected—was a universal single-payor public prescription drug plan. The second option was to reform Canada's current system to ensure wide coverage by filling any gaps between public and private plans.

Regarding costs, the report references the Parliamentary Budget Office that estimates potential savings of $4.2 billion annually. This would be due to a national prescription drug formulary that would enhance consistency in drug coverage across Canada and enable improved price negotiations. But, before the savings are possible, the report indicates that governments would likely assume approximately $10.7 billion in costs currently shouldered by private insurers. To address costs, the report recommends cost-sharing between federal, provincial, and territorial governments; however, it doesn't provide details of how costs would be divided.

What is the insurance industry's response? Although the Canadian Life and Health Insurance Association recognizes that there is consensus regarding the need for change, that reform should be done in a way that protects taxpayers and doesn't put health plans at risk. Specific concerns include that the report's recommendations represent an expensive approach to addressing the issue of access to drugs and could end up reducing the quality of health benefits plans available to Canadians.

For more information and to access the report, visit https://www.ourcommons.ca/DocumentViewer/en/42-1/HESA/report-14/.

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REPORT RECOMMENDS CHANGES TO PAN-CANADIAN HEALTH ORGANIZATIONS

Health Canada recently released the report *Fit for Purpose: Findings and Recommendations of the External Review of the Pan-Canadian Health Organizations*. Referred to as PCHOs, Health Canada describes these organizations as "self-governing, not-for-profit agencies with representation from governments, experts, and stakeholders."

The PCHOs were established over the past 30 years to address specific Canadian health care system needs and to help meet federal health care objectives. The PCHOs were left to determine their own priorities, which they did largely in isolation from the federal government and from each other. However, the current role of the PCHOs is insufficient to meet today's challenges and those of the future.

The report is the outcome of an independent review by external advisors that included input from a wide range of public and private sector representatives. Recommendations concern the role and impact of PCHOs in helping meet federal and Canada-wide health objectives and priorities. In addition, the report recommends how PCHOs should be reconfigured to meet emerging health care issues and a common federal, provincial, and territorial vision of health care for Canada.

The report includes ten recommendations that the advisors feel should be considered no matter how the PCHOs end up being reconfigured. For example, "The Government of Canada should establish an integrated infrastructure for prescription drug policy that connects approvals, assessment, pricing, purchasing, and post-market surveillance. The assessment of health technologies should be carried out by leveraging the existing network of qualified agencies across the country."

WIDE RANGE OF INPUT

The report's external advisors conducted consultations and solicited feedback from a wide range of representatives from provincial and territorial governments, national indigenous organizations, patient groups, health care providers, academic experts, private sector groups, and health care system leaders, researchers, and experts, as well as individuals and Canada's eight PCHOs:

- → Canadian Centre on Substance Use and Addiction
- → Canadian Agency for Drugs and Technologies in Health
- → Canadian Institute for Health Information
- → Canadian Foundation for Healthcare Improvement
- → Canada Health Infoway
- → Canadian Patient Safety Institute
- → Canadian Partnership Against Cancer
- → Mental Health Commission of Canada

With the recommendations as the foundation for change, the report also outlines four possible scenarios for PCHOs in the future with the idea that elements from each scenario could also be considered to create additional scenarios. Scenario number one outlines improvements without fundamental restructuring of the PCHOs, whereas scenarios two, three, and four outline larger-scale transformations of the PCHOs.

As the federal government reviews the report, we'll keep you posted of any action. For more information and to view the report, visit https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/findings-recommendations-external-review-pan-canadian-health-organization.html.

OUT & ABOUT... *Events not to miss*

Healthy Outcomes Conference

May 24-25 – Four Seasons Hotel, Toronto, Ontario

http://www.benefitscanada.com/conferences/healthy-outcomes-conference

Peter Gove, GSC's innovation leader – health management, will be speaking about wellness/health management program accessibility.

Calgary Benefits Summit

May 29 – Fairmont Palliser Hotel, Calgary, Alberta

www.benefitscanada.com/conferences/calgary-benefits-summit

Andrea Staruch, one of GSC's pharmacy services consultants, will be speaking about biosimilars and the evidence supporting patient transition programs.

FITBIT WINNER

Congratulations to **M. PIPES**, of **VICTORIA, BC**, the winner of our monthly draw for a Fitbit. Through this contest, one name will be drawn each month from plan members who have registered for Plan Member Online Services for that month.

Windsor	1.800.265.5615	**Vancouver**	1.800.665.1494
London	1.800.265.4429	**Montréal**	1.855.789.9214
Toronto	1.800.268.6613	**Atlantic**	1.844.666.0667
Calgary	1.888.962.8533	**Customer Service**	1.888.711.1119

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