

George W Bush's second term

Many domestic and international health policies are likely to be controversial

When George W Bush returns to the White House after his inauguration ceremony, health is unlikely to be at the top of his agenda. In the months ahead he must devise strategies that will tackle record budget and trade deficits and pave the way for an exit from an increasingly unpopular war in Iraq. Yet many of the other decisions that he and his administration must make will have profound consequences for the health of America's people and for those in many other countries.

That the American healthcare system is in a mess has long been apparent. Despite spending vast and ever increasing amounts of money (now over a third more per person than Switzerland, the next highest spender), uniquely among industrialised countries the United States does not attempt to provide cover for all its citizens, and the number of uninsured people has increased from 42 million to 45 million in the past four years. Although the country spends almost 15% of its national income on health care, its outcomes are appalling, with death rates among young people from some common chronic diseases three or four times higher than in European countries.¹ The reforms that are being proposed contain some potentially good ideas, such as reform of the law on malpractice claims, expansion of community health centres, and help for small businesses to become more effective purchasers of insurance.² Others are seriously misguided, most notably the concept of health savings accounts.

An individual enrolled in a health savings account receives coverage for catastrophic illness. Other health care must be paid first by the individual, up to a defined limit (typically several thousand dollars), after which they can draw on the tax free fund into which they and their employer have paid. Any money in this fund that is unspent at the end of the year is rolled over to provide, hopefully, a reasonable pool for any future needs. Accounts appeal to wealthy people, who are likely to leave existing schemes.³ Those remaining will be disproportionately poor and unhealthy⁴ and will face higher premiums because of the loss of cross subsidy, which will further increase the number of uninsured people.

Several other domestic policies are likely to prove controversial. The expected change in the composition of the Supreme Court will facilitate a review of the legality of abortion. Social policies will emphasise fundamentalist views on sexuality and family relationships,⁵ with sex education based on the ineffective model of promoting abstinence.⁶ As a consequence, the already high rate of teenage pregnancies is likely to increase further.

The ability to respond to the challenges ahead will be constrained by the growing politicisation of American science. The Union of Concerned Scientists has catalogued how the first Bush administration sought to suppress or distort research deemed unhelpful or out of line with its socially conservative policies.⁷ A congressional committee has documented how this degree of political interference is unprecedented in the United States, noting that the consequences of this process go far beyond the delivery of health care to affect policies on education, the environment, and many other areas.⁸

As the United States is the one remaining global superpower, policies adopted in Washington have implications for the world. The Bush administration has pursued a sustained campaign against multilateralism, seeking to block action on issues as diverse as global warming and landmines. It has decided that the Geneva conventions do not apply to some of its prisoners and has refused to accept the authority of the International Criminal Court. The United Nations has been subjected to vitriolic attacks in the American media, and the Bush administration has sought, where possible, to lead coalitions of the willing that bypass the UN and its specialised agencies. An example is the President's Emergency Plan for AIDS Relief, which exists in parallel with, and arguably undermines, the Global Fund to fight AIDS, Tuberculosis, and Malaria by diverting needed resources. The president's emergency plan has been slow in spending the money made available to it, and much of what has been spent has been used to purchase expensive patented drugs instead of cheaper generics.⁹

Such mechanisms are attractive to the administration as they provide a means of projecting domestic policies on, for example, sexuality, to many other countries, a process aided by the global gag rule in which any organisation receiving American government funds must agree not to provide counselling for those seeking abortion or lobby for its legalisation. Some signs, however, show that the administration is reviewing this approach as illustrated by its rapid abandonment of the four country coalition created to provide relief to the victims of the tsunami in the Indian Ocean.

Like other second term presidents George W Bush will have one eye on his place in history. The greatest epitaph for a politician is that they leave the world in a better state than they found it. History will be the judge.

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Opioids for persistent non-cancer pain

A team approach and individualisation of treatment are needed

Epidemiological studies from Australia and Denmark indicate that about 19% of the population is afflicted by chronic pain that is not caused by cancer.^{1 2} The prevalence of chronic pain that interferes with daily activities is 12.6%.¹ In most Western countries, opioids are established in treating pain due to cancer, and they are increasingly used to manage chronic pain not due to cancer. Opioids are effective analgesics, but they also have a strong reinforcing potential—fear of addiction and diversion restrict their medicinal use. Good clinical trials, guidelines, and responsible prescription are needed to ensure the availability of opioids for those patients who may benefit.^{3 4}

A recent systematic review included 11 randomised and controlled trials on oral opioids in non-cancer pain.⁵ The review showed that opioids provided pain relief for both neuropathic (postherpetic neuralgia, diabetic neuropathy) and musculoskeletal pain (osteoarthritis). Large differences between individuals in the response to opioids in all conditions implied that the effectiveness of the treatment should be tested in each individual. Adverse effects were common and included constipation, nausea, vomiting, somnolence, sedation, dizziness, itching, dry mouth, and headache. The studies were of short duration (four days to eight weeks in each treatment arm). Some studies included an open label phase for up to two years, but only a few patients continued to use opioids.

When treating pain due to cancer, alleviating symptoms is the main goal, whereas in the management of chronic non-cancer pain the goal is to keep the patient functional, both physically and mentally, with improved quality of life. Relief of pain may be an essential factor in this and opioids are only one aspect of the overall rehabilitative strategy for the patient. In a few instances, such as when an elderly patient is waiting for a hip replacement, opioids can be regarded as a fairly straightforward means of alleviating pain for a limited period. The more chronic and complex the problem and the younger the patient, the lesser is the role opioids have in the rehabilitation plan. A multidisciplinary pain clinic will try other analgesics (including antidepressants and anticonvulsants), non-steroidal anti-inflammatory drugs, weak analgesics, transcutaneous nerve stimulation, cognitive behaviour therapy, and exercise programmes.

Opioids are not effective in every patient with pain. Randomised controlled trials indicate that no criteria

have been identified that predict good response to opioids in any particular condition. Also, these trials were of short duration and included a selected group of patients. Many questions regarding safety, such as long term effects on hormonal and immune function, development of tolerance and increased pain sensitivity, addiction and diversion of drugs were not answered by these trials.⁶ Therefore, each patient who is considered for treatment with opioids needs to be assessed for both efficacy and safety. Good monitoring serves the individual patient and provides valuable information from areas that cannot be studied in randomised and placebo controlled studies, such as tolerance, addiction, and diversion of drugs.

Patients need to be informed of the possible benefits and risks of opioid treatment, and they need to be monitored carefully. This takes time. Treatment of young patients and patients with psychosocial problems or addictive behaviour should be initiated in multidisciplinary pain clinics that have the resources and expertise to assess these problems. However, primary care doctors should always be involved in the decision making as they will usually take responsibility for the patients in the long term. Multidisciplinary pain clinics should be available for consultation if problems occur. These clinics should also follow and audit to ensure that information gained over the years is used to reassess the appropriateness of the treatment.

Opinions regarding the medicinal use of opioids have always been polarised. History shows how too liberal use has led to heightened regulatory control, reluctance of doctors to prescribe opioids, and under-treatment of pain. Guidelines are needed to prevent history repeating itself. The British Pain Society published its recommendations for the appropriate use of opioids for persistent non-cancer pain in March 2004.⁴ The document includes information for the patient, who is an important partner in the treatment plan. The recommendations were carefully worked out with consultations of the royal colleges of anaesthetists, general practitioners, and psychiatrists. They are based on what is known about the effectiveness of opioids in the treatment of chronic non-cancer pain. The recommendations acknowledge the lack of data in many important areas of clinical research; in these areas they are based on clinical experience. The recommendations provide an excellent

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