Reports of Original Investigations

Challenges in accessing multidisciplinary pain treatment facilities in Canada

[Les défis de l'accès aux établissements pluridisciplinaires de traitement de la douleur au Canada]

Philip Peng FRCPC,* Manon Choiniere PhD,† Dominique Dion MD MSc,‡ Howard Intrater FRCPC,§ Sandra LeFort PhD,¶ Mary Lynch FRCPC,|| May Ong FRCPC ,**Saifee Rashiq MSc (Epid) DA (UK) FRCPC,†† Gregg Tkachuk PhD,‡‡ Yves Veillette FRCPC,§§ STOPPAIN Investigators Group

Purpose: The objective of this survey was to examine the services offered by multidisciplinary pain treatment facilities (MPTFs) across Canada and to compare access to care at these MPTFs.

Methods: A MPTF was defined as a clinic that advertised specialized multidisciplinary services for the diagnosis and management of patients with chronic pain, having a minimum of three different health care disciplines (including at least one medical speciality) available and integrated within the facility. The search method included approaching all hospital and rehabilitation centre administrators in Canada, the Insurance Bureau of Canada, the Workplace Safety and Insurance Board or similar body in each province. Designated investigators were responsible for confirming and supplementing MPTFs from the preliminary list for each province. Administrative leads at each eligible MPTF were asked to complete a detailed questionnaire regarding their MPTF infrastructure, clinical, research, teaching and administrative activities.

Results: Completed survey forms were received from 102 MPTFs (response rate 85%) with 80% concentrated in major cities, and none in Prince Edward Island and the Territories. The MPTFs offer a wide variety of treatments including non-pharmacological modalities such as interventional, physical and psychological therapy. The median wait time for a first appointment in public MPTFs is six months, which is approximately 12 times longer than non-public MPTFs. Eighteen pain fellowship programs exist in Canadian MPTFs and 64% engage in some form of research activities

Conclusion: Canadian MPTFs are unable to meet clinical demands of patients suffering from chronic pain, both in terms of regional accessibility and reasonable wait time for patients' first appointment.

CAN J ANESTH 2007 / 54: 12 / pp 977–984

***Objectif** : L'objectif de ce sondage était d'examiner les services offerts par les établissements pluridisciplinaires de traitement de la douleur (MPTF – multidisciplinary pain treatment facility) au Canada et de comparer l'accès aux soins dans ces MPTF.*

From the Wasser Pain Management Centre,* Mount Sinai Hospital, University of Toronto, Toronto, Ontario; the Department of Anesthesia,† Montreal Heart Institute, Faculty of Medicine, University of Montreal, Montreal, Quebec; the Department of Family Medicine,‡ Hôpital Maisonneuve-Rosemont, Faculty of Medicine, University of Montreal, Montreal, Quebec; the Health Science Centre Pain Clinic,§ Winnipeg, Manitoba; the School of Nursing,¶ Memorial University, St. John's, Newfoundland; the Pain Management Unit,|| Queen Elizabeth II Health Centre, Halifax, Nova Scotia; the St Paul's Hospital,** Vancouver, British Columbia; the Multidisciplinary Pain Centre,†† University of Alberta Hospital, Edmonton, Alberta; the Chronic Pain Centre,‡‡ Saskatoon Health Region, Saskatoon, Saskatchewan; the Department of Anesthesia, Clinique Anti-douleur,§§ Hôpital Maisonneuve-Rosemont, Faculty of Medicine, University of Montreal, Montreal, Quebec, Canada.

Address correspondence to: Dr. Philip Peng, McL 2-405 Toronto Western Hospital, 399 Bathurst Street, Toronto, Ontario M5T 2S8, Canada. Phone: 416-603 5118; Fax: 416-603 6494; E-mail: philip.peng@uhn.on.ca

Funding: The study was funded by the Canadian Institutes of Health Research (via the CIHR/Rx&D Collaborative Research Program) in partnership with Pfizer Canada and the three networks of the Fonds de la recherche en santé du Québec (Santé buccodentaire, Adaption-réadaption, Neurosciences et santé mentale).

Competing interest: None declared.

Accepted for publication July 10, 2007.

Revision accepted August 27, 2007.

This article is accompanied by an editorial. Please see Can J Anesth 2007; 54: 963–8.

Méthode *: Un MPTF a été défini comme une clinique affichant des services pluridisciplinaires spécialisés pour le diagnostic et la prise en charge des patients souffrant de douleurs chroniques, et possédant au moins trois disciplines différentes de soins de santé (y compris au moins une spécialité médicale) à disposition et intégrées dans l'établissement. La méthode de recherche comprenait la prise de contact avec tous les administrateurs d'hôpitaux et de centres de réhabilitation canadiens, le Bureau d'assurance du Canada, la Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail ou avec d'autres organismes similaires dans chaque province. Des chercheurs désignés étaient responsables pour la confirmation et l'ajout de MPTF à la liste préliminaire dans chaque province. On a demandé à la direction administrative de chaque MPTF éligible de remplir un questionnaire détaillé concernant l'infrastructure de son MPTF ainsi que ses activités de soins, de recherche, d'enseignement et de gestion.*

Résultats *: Des formulaires de sondage complétés ont été reçus de 102 MPTF (taux de réponse de 85 %), dont 80 % sont situés dans des grandes villes, et aucun sur l'Ile du Prince Edouard et les Territoires. Les MPTF offrent une grande diversité de traitements, y compris des modalités non pharmacologiques, comme par exemple les traitements interventionnels, physiques et psychologiques. Le temps d'attente médian pour un premier rendez-vous dans un MPTF public est de six mois, ce qui est environ 12 fois plus long que dans un MPTF non public. Dix-huit programmes de fellowship en douleur existent dans les MPTF canadiens, et 64 % de ces établissements ont des activités de recherche.*

Conclusion *: Les établissements pluridisciplinaires de traitement de la douleur canadiens ne peuvent répondre aux demandes cliniques de patients souffrant de douleurs chroniques, que ce soit en termes d'accessibilité régionale ou de temps d'attente raisonnable pour le premier rendez-vous d'un patient.*

CHRONIC pain is a significant health problem in Canada. It affects approximately one in five Canadian adults.[1,2,A] Chronic pain is more prevalent than other well-known chronic illness such as diabetes mellitus[B] or asthma,[C] and its prevalence increases steadily with advancing age.[1,3] It profoundly affects the quality of life of its sufferers, their work, mood, and social relationship.[4–6] In the United States, it has been estimated that the combined direct and indirect cost of chronic pain exceeds $125 billion US per year.[7] In the United Kingdom, back pain alone was found to impose an economic burden greater than coronary heart disease and diabetes mellitus together.[8]

Because of the deleterious consequences of chronic pain on the patient's psychosocial and physical functioning,[4,5,9] a multidisciplinary team approach is considered the optimal treatment paradigm by expert bodies such as the International Association for the Study of Pain.[D,E] Clinical practice guidelines developed by the Colleges of Physicians and Surgeons of Alberta, New Brunswick, Manitoba and Ontario also endorse the use of a multidisciplinary approach for the treatment of chronic pain,[F,G,H,I] but little is known about the availability of this type of treatment in Canada.[J] The objective of this study was to examine the distribution of multidisciplinary pain treatment facilities (MPTFs) across Canada, to describe the services they offer and the access of care to these facilities.

Methods

Definition of MPTFs

In the present study, a MPTF was defined as a health care delivery facility staffed with health care professionals specialized in the diagnosis and management of patients with chronic pain. To be included in the study, the MPTF had to 1) advertise itself as a pain

A *Statistic Canada*. Health Indicators. 82-221-XIE. 2002. Statistic Canada.

B *Statistics Canada*. Health Indicators. 82-221, Vol. 2006 No. 1 Statistic Canada.

C *Statistics Canada*. National Population Health Survey (NPHS), 1994/95; Population aged 15 and over.

D Task Force on Guidelines for Desirable Characteristics for Pain Treatment Facilities, IASP. Desirable characteristics for pain treatment facilities. Available from URL; http://www.iasp-pain.org/desirabl.html (accessed August 12, 2006).

E *Ospina, M, Harstall, C.* Multidisciplinary Pain Programs for Chronic Pain: Evidence from systematic reviews. Alberta Heritage Foundation for Medical Research - Health Technology Assessment, Alberta, Canada, 2003: 1–48.

F *College of Physicians and Surgeons of Alberta*. Management of Chronic Non-malignant Pain - CPSA Guideline. Available from URL; http://www.cpsa.ab.ca/home/home.asp (accessed August 12, 2006).

G *College of Physicians and Surgeons of New Brunswick*. Guidelines of Management of Chronic Non-Malignant Pain. Available from URL; http://www.cpsnb.org/ (accessed August 12, 2006).

H *College of Physicians and Surgeons of Manitoba*. Management of Chronic Non-Malignant Pain. Available from URL; http://www.cpsm.mb.ca (accessed August 12, 2006).

I *College of Physicians and Surgeons of Ontario*. Evidence-based Recommendations for Medical Management of Chronic Non-Malignant Pain : Reference Guide for Clinicians. Available from URL; http://www.cpso.on.ca/ (accessed August 12, 2006).

J Agence d'évaluation des technologies et des modes d'intervention en santé (AETMIS). Management of Chronic (Non-Cancer) Pain: Organization of Health Services (AETMIS 06-04). Montréal: AETMIS, 2006, xv-85 pp.

TABLE Distribution of MPTFs in different provinces in Canada

	# Eligible	*# MPTFs*	*Per population*	*Urban (%)*
Newfoundland	1	1	1/508K	1 (100)
Prince Edward Island	0	0	0/133K	N/A
Nova Scotia	4	4	1/224K	3 (75)
New Brunswick	6	3	1/119K	2 (66)
Quebec	29	26	1/254K	19 (73)
Ontario	37	35	1/305K	29 (83)
Manitoba	2	1	1/552K	1 (100)
Saskatchewan	20	13	1/48K	10 (77)
Alberta	14	12	1/226K	9 (82)
British Columbia	7	7	1/552K	7 (100)
Three Territories	0	0	0/92K	N/A
Canada	120	102	1/258K	81 (80)

MPTF = multidisciplinary pain treatment facilities; NA = not applicable.

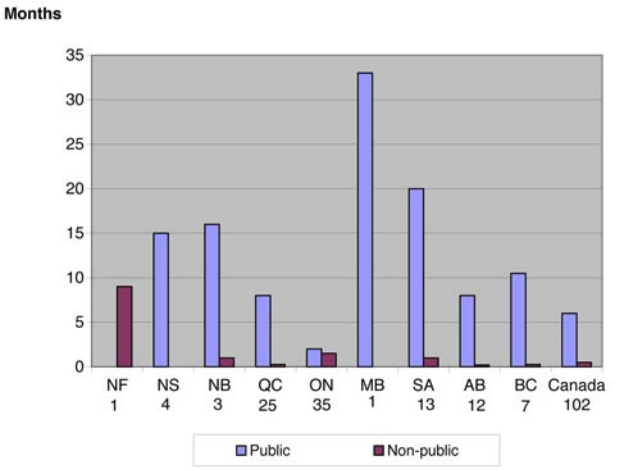

FIGURE 1 Wait time to first appointment in "public" and "non-public" multidisciplinary pain treatment facilities (MPTFs) in different provinces. Note that the median wait time in all adult public MPTFs in Nova Scotia was 16 months (range one to five years). The wait time in Nova Scotia presented in the figure includes a pediatric MPTF where the wait time was 0.4 month. In New Brunswick, data for the wait time of the non-public MPTF was unavailable. The number of MPTFs surveyed by province is indicated along the X axis under each province.

clinic or a pain centre providing specialized multidisciplinary services for the diagnosis and management of patients with chronic non-malignant pain; and 2) be staffed with professionals from a minimum of *three* different healthcare disciplines (whose services were available and *integrated* within the pain clinic or centre) including at least one medical specialty. An example would be a MPTF staffed with an anesthesiologist, a psychologist, and a physiotherapist.

Search strategy

Because there was no pre-existing complete list of MPTFs in Canada, a comprehensive search strategy was used to identify all existing MPTFs. To identify hospital-based MPTFs, letters were sent to the medical directors and/or chief executive officer of all hospitals and rehabilitation centres across Canada, asking whether there was a pain clinic or a pain centre within their institution. The complete list of those hospitals or healthcare facilities was obtained from Guide to Canadian Healthcare facilities 2004–5 (Canadian Healthcare Association). Upon confirmation of presence of a pain clinic, they were asked to provide the name of the director and contact information of the clinic. Non-hospital based or private clinics were identified by contacting the Insurance Bureau of Canada, compensation agencies (work or car accident), and local pharmaceutical industry representatives. Following this process, a preliminary list was made available to the study representatives of each province (provincial representatives), who were pain clinicians or researchers with an excellent knowledge of the pain clinics and centres in their provinces. Each provincial representative reviewed the list to ensure its completeness. They then contacted each pain clinic to verify their eligibility based on the definition of MPTF described above.

Survey questionnaire

With Institutional Review Board approval obtained from the University of Montreal, the directors or administrators of the potential MPTFs were sent by regular or electronic mail an invitation letter along with a questionnaire. If the completed questionnaires were not returned within three weeks, the directors were reminded by mail or phone. Upon receipt of the questionnaire, a research assistant carefully reviewed all items to ensure that each question had been answered. If some information was missing or unclear, the research assistant clarified the information by telephone.

The survey questionnaire used in this study was adapted from the Quebec Chronic Pain Clinic Survey.[10] It covered: 1) the organizational structure of the MPTF, 2) clinical activities such as the volume of patients, wait lists, spectrum of chronic pain con-

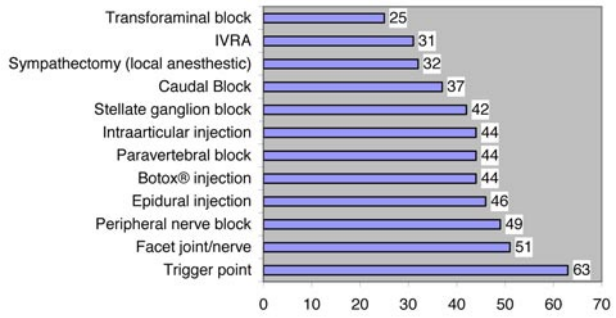

FIGURE 2 Types of interventional procedure offered in multidisciplinary pain treatment facilities (MPTFs) in Canada. Data are expressed as percentage of MPTFs. IVRA = intravenous regional anesthesia

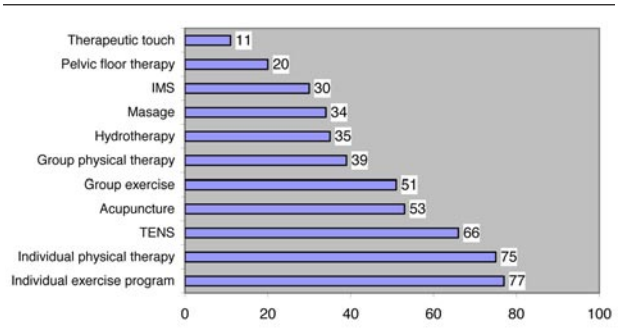

FIGURE 3 Types of physical therapy offered in multidisciplinary pain treatment facilities (MPTFs). Data are expressed as percentage of MPTFs. IMS = intramuscular stimulation; TENS = transcutaneous electrical nerve stimulation.

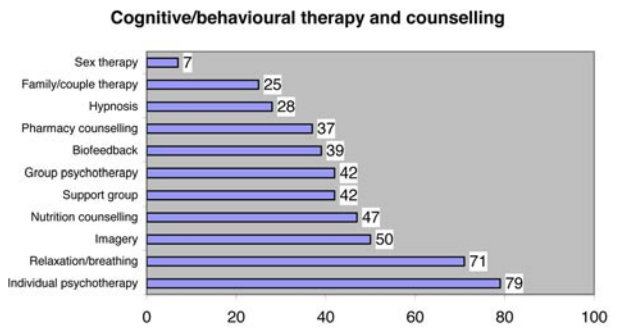

FIGURE 4 Types of psychological treatment and counseling offered in multidisciplinary pain treatment facilities (MPTFs). Data are expressed as percentage of MPTFs.

ditions treated, and treatment modalities offered or available within the institution, 3) staff composition and availability, 4) teaching and research activities, and 5) the type of funding for services and overhead. The full questionnaire is available as additional material online at www.cja-jca.org. Data were collected from June 2005 to August 2006.

Data analysis and presentation

Data collected in this study were analyzed with standard descriptive statistics using the SPSS-version 11 (Chicago, IL, USA). The data are presented as frequencies, medians and 25–75% interquartile ranges.

Results

A total of 988 hospitals and rehabilitation centers were identified and 321 provided contact information for 52 pain clinics in their facilities. Further search of hospital, non-hospital based and private MPTF via compensation agencies (work or car accident), the Insurance Bureau of Canada, and pharmaceutical industry representatives yielded another 84 pain clinics. In addition, the national sales managers of pharmaceutical companies who market products for pain management were contacted to identify any additional pain clinics which were not included in the initial search. After screening these 136 clinics, only 120 met the study selection criteria and representatives from 85% of eligible clinics completed and returned the survey questionnaire.

Distribution of MPTFs

Distribution of the 102 MPTFs in different provinces is shown in the Table. No MPTF was found in Prince Edward Island or the Territories. The majority of the MPTFs (80%) were concentrated in major cities. In Manitoba, Newfoundland and British Columbia, MPTFs were found exclusively in urban areas. It was estimated that one MPTF served an average of 258,000 Canadians.

Workload and wait times in MPTFs

Most of the MPTFs reported operating on a full time basis with a median of five (4.4–5) operating days per week. Across Canada, this represented a total of 46,000 new consultations and 529,000 follow-up visits per year. Wait time for a first appointment was highly variable and was mainly a function of the type of funding of the MPTFs. For the purposes of the present analysis, the MPTFs were divided into two types - public and non-public - based on their major funding source for patient services. In public MPTFs (60%), the major source of funding for patients

service was provided by the provincial health insurance plan, whereas in non-public MPTFs (40%), the major source of funding for patient service came from compensation agencies, insurance companies or the patients themselves. Striking differences in distribution and wait time in these two types of MPTFs were observed. In Saskatchewan, all but one[K] MPTFs were non-public while all MPTFs were public in Nova Scotia. The median wait times of the public and non-public MPTFs were six months (2–14) and 0.5 months (0.3–1) respectively. Wait times of public and non-public MPTFs in different provinces is shown in Figure 1. The wait time was more than one year in 31% of the public MPTFs and could be as long as five years. In contrast, wait time was less than two months in 88% of non-public MPTFs.

Clinical activities of MPTFs

Most MPTFs (78%) accept adult patient referrals exclusively; only five MPTFs were specifically designated for children. Twenty-eight percent of MPTFs use the duration of pain as an inclusion criterion for referrals (more then three months - 18%; more than six months-10%). Seventeen percent of MPTFs accept referrals for only certain pain syndromes (e.g., fibromyalgia, complex regional pain syndrome, musculoskeletal pain or neuropathic pain), while 14% of MPTFs exclude certain pain syndromes for referrals (e.g., diffuse multi-site pain, fibromyalgia or headache). Of the commonest managed pain syndromes, low back pain was ranked as the top pain syndrome (28%) followed by neck pain (22%), neuropathic pain (11%), headache (10%), fibromyalgia (7%), and complex regional pain syndrome (7%).

Canadian multidisciplinary pain treatment facilities offer a variety of non-pharmacological therapies including interventional, physical, and psychological therapies (Figures 2–4). The percentage of MPTFs offering at least one type of interventional technique, physical therapy and psychological treatment were 75%, 78% and 76% respectively. A wide variety of structured pain management programs were offered by 40% of MPTFs. They included back school, coping strategy programs, functional restoration programs, classes for neck care, yoga, medication, stress management, and self-management for specific pain syndromes (e.g., fibromyalgia, complex regional pain syndrome or angina).

Teaching and research activities

Training for residents or students of different healthcare professions was offered in 76% of MPTFs. Only 18 pain fellowship programs were available, of which 14 were provided by anesthesiology departments. Research activities takes place in 64% of the MPTFs, and 35% have at least one designated research coordinator. Each MPTF with research activity reported their involvement in either two or three projects at the time of this survey.

Discussion

This comprehensive national survey examining the distribution and services offered in MPTFs across Canada demonstrates the variability and extent to which MPTFs are unable to meet clinical demands. Patients from Prince Edward Island, the three Territories and the vast majority of rural areas across all provinces do not have access to such services in their own region. Statistics Canada defines a major metropolitan area (Census Metropolitan Area) as one with an urban core population greater than 100,000, and a mid-size urban centre as being an urban centre with a population greater than 10,000. Based on the information from Census 2006, approximately 80% of Canadians dwell in urban centers of populations greater than 10,000, and 68% of these individuals live in the country's 33 major metropolitan areas.[L] Our results show that 98% and 82% of MPTFs are located in mid-size urban centres and major metropolitan centres, respectively. As a result of the geographic maldistribution, chronic pain sufferers residing outside those urban areas must rely principally on the care provided by family physicians and pain specialists in their local areas. With the shortage of family physicians[11,12] and limited number of pain specialists,[M] chronic pain sufferers are challenged to obtain care or have to consider traveling long distances to major cities for appropriate pain management. In both situations, wait times are expected to be long, and the patient's condition is likely to continue to deteriorate during that period. Furthermore, long transportation times and prolonged sitting usually aggravate the pain and suffering experienced by patients with musculoskeletal diseases.[13,14]

Although not every patient suffering from chronic pain requires a multidisciplinary approach,[15] services

K In Saskatchewan, the only public MPTF is actually funded from a combination of public and non-public sources. The decision to include this centre as a public MPTF was based on the fact that the majority of treated patients are not supported directly by third-party insurance.

L *Statistic Canada*. Portrait of the Canadian Population in 2006, 2006 Census. Catalogue no. 97-550-XIE.

M Action Atlantic. Survey of Atlantic Pain Physician Wait-Times Available from URL; http://www.paincantwait.ca/images/Atlantic_Pain_Survey.doc (accessed October 10, 2006).

provided by MPTFs are considered the optimal therapeutic paradigm for the management of chronic pain patients. In our study, the median wait time for an appointment at a public MPTF was six months. This means that 50% of patients must wait six months, 12 months or even up to five years to gain access to appropriate treatment for their pain. Another disturbing finding is the unequal access of care to MPTFs based on their source of funding. The wait time for public MPTFs is approximately 12 times longer than that of non-public MPTFs.

For many years, it was thought that the pain itself is not a lethal entity. There is mounting evidence, however, that in some cases pain can contribute to overall mortality. It has been demonstrated that uncontrolled pain compromises immune function, promotes tumour growth, and can compromise healing with an increase in morbidity and mortality following surgery.[16,N] Chronic pain has been found to double the risk of death by suicide as compared to controls.[17] Often chronic pain may cause more suffering and disability than the injury or illness that caused it in the first place.[18] Despite the prevalence of chronic pain, undertreatment of pain is a societal problem.[6] More than ten years ago, Somerville, a bioethicist, wrote, "*Leaving a person in unavoidable pain and suffering should be regarded as a serious breach of fundamental human rights*".[19] In a recent Supreme Court decision in 2005 in favour of Dr. Chaoulli and Mr. Zelliotis,[O] the Honorable Justice Deschamps acknowledged the issue of pain and quality of life in stating; *"The evidence also shows that many patients on non-urgent waiting lists are in pain and cannot enjoy any real quality of life. The right to life and personal inviolability is therefore affected by waiting times"*. In concurring statements, the honorable Justice McLachlin states; *"Where lack of timely healthcare can result in death, the s. 7 protection of life is engaged; where it can result in serious psychological and physical suffering, the s. 7 protection of security of the person is triggered"*.

In times of escalating medical costs, legislators strive to prioritize health care resources. In September of 2004, Canadian First Ministers acknowledged the importance of the issue of timely access to healthcare and announced a Ten Year Plan to Strengthen Healthcare.[P] Five priority areas (cancer, cardiac care, diagnostic imaging, joint replacement and sight restoration) were identified but chronic pain was *excluded*. In December 2005, the Canadian Pain Society struck a Wait Times Task Force (CPSWTTF) to identify benchmarks for acceptable wait times for treatment of chronic pain. Their systematic review[Q] suggested that waits of six months or more for treatment of chronic pain are associated with deterioration in health related-quality of life and psychological well being including an increase in depression levels.

For chronic pain sufferers, it may be difficult to understand the discrepancies in wait times. If their injuries are covered by compensation agencies or insurance companies, or if they are willing to pay themselves, the wait list is 12 times shorter. The universal healthcare system of Canada is unique in that it prohibits coverage of core services by private insurance companies, allowing supplemental insurance only for perquisites such as private hospital rooms.[20] The Supreme Court decision discussed above implies that provincial governments cannot ban private care unless they guarantee that the public system will meet patients' needs without excessive waits.[21] In February 2006, Quebec announced that it would improve access within the public system to certain services (e.g., joint replacement) within six months after they are recommended by a specialist.[R] If these services cannot be provided within that time frame, Quebec will pay for services at an affiliated private clinic in the province, or outside the province if the time frame further exceeds nine months. With the CPSWTTF recommendation that patients wait not longer than six months for treatment for chronic pain, our findings should alert policy makers and healthcare professional bodies to re-examine the strategies to shorten the wait times for chronic pain sufferers.

In addition to the source of funding for patients services, other factors may contribute to the discrepancies in wait times, such as treatment philosophy and setting of practice (academic centre, hospital affiliated or free standing clinic). The wait times in

N *Page GG*. Acute pain and immune impairment. Pain Clinical Updates 2005; XIII: 1-4.

O *Chaoulli V*. Quebec (Attorney General), No. 29272, Sup. Ct. of Canada 130 C.R.R. (2d) 99; 2005 C.R.R. LEXIS 76.

P *Canadian Institute for Health Information*. Plan for reporting comparable health indicators in November 2004. Ottawa 2004. Available from URL; http://secure.cihi.ca/cihiweb/en/downloads/ ACGA_CBN_TO_CDM_ENG.pdf (accessed August 16, 2007).

Q *Lynch M, Campbell F, Clark J, et al.* A systematic review of the effect of waiting for treatment for chronic pain. Available from URL; http://dx.doi.org/10.1016/j.pain.2007.06.018 (accessed September 3, 2007).

R *Government of Quebec*. Guaranteeing access: meeting the challenges of equity, efficiency and quality-consultation document. Available from URL; http://publications.msss.gouv.qc.ca/acrobat/f/ documentation/2005/05-721-01A.pdf (accessed October 13, 2006).

those MPTFs that are program-based are likely to be shorter as they have clear patient discharge endpoints. For instance, a MPTF that only provides a cognitive behavioural program usually provides active treatment for a period ranging from eight to 24 weeks. Although this program may provide some sporadic follow-up, it frees up the clinical workload of the MPTF, allowing the health care providers to manage another group of patients. Another end of the spectrum will be exemplified by a MPTF which provides pharmacological, physical, cognitive-behavioural and interventional modalities of treatment, but some of those treatments cannot be continued by the referral or family physicians for various reasons. In this situation, the number of follow-up patients becomes staggered, the workload of caring for existing patients increases, and the wait times for new referrals will be lengthened proportionately. Unfortunately, it is impractical to survey the treatment philosophy of these MPTFS in a 'check box' fashion. The setting of practice can influence the wait time, and the wait times in university or hospital affiliated MPTFs are generally longer. However, they are mostly 'public' and there are other issues as well, such as patient referral patterns, and the presence of teaching and research in those MPTFs, making the interpretation of disparities of wait times difficult.

Limitations of this survey need to be conisdered. First, we could not exclude the possibility that some eligible MPTFs were missed. We contacted *all* the hospitals and rehabilitation centres across Canada but the response rate was disappointing (33%). However, we were able to increase our recruitment by contacting the Insurance Bureau of Canada, provincial compensation agencies, and local pharmaceutical industry representatives. Most importantly, great care was taken to identify within each province a study representative who had an excellent knowledge of the pain treatment facilities in his/her province through his/her contacts with professional organizations or provincial pain societies. These persons had a key role in identifying missing MPTFs on the list with which they were provided. In terms of response rate, 102 of the 120 eligible MPTF (85%) returned the survey questionnaire. Considering the nature and objectives of our survey, we believe that this response rate is reasonable and allows some generalizations from the present sample. A second limitation realtes to the data collection methodology (self-administered questionnaire *vs* face-to-face interview). However, all precautions were taken to ensure appropriate comprehension and completion of the questions.

In conclusion, this study revealed a maldistribution of MPTFs across Canada. Wait times to first appointment depend to a considerable extent on the funding model, and are approximately 12 times longer in public MPTF when compared with non-public MPTFs. The median wait time was six months in public MPTFs but in 31% of facilitities, it ranged from one to five years. Canadian MPTFs are clearly unable to meet the clinical demand both in terms of regional accessibility and reasonable wait times to first appointment. These disturbing results should alert policy makers and healthcare professionals to re-examine the current level of services and access to those services, and their impact on the provision of optimal care for patients suffering from chronic pain.

Acknowledgements

We sincerely thank Chelsea Maddock and Diana Bereti for their assistance in data collection and data analysis. We also extend our gratitude to all the research coordinators and associates for their tireless efforts in the conduct of this survey.

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