PRE-BUDGET SUBMISSION 2015-16

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working to prevent and manage pain

CONTENTS

EXECUTIVE SUMMARY

The Federal Government has a clearly articulated set of policies which aim to:

- Improve productivity and keep older Australians in the workforce (Federal Budget – Economic Action Plan).[1]
- Ensure effective management of the social security portfolio budget including the Disability Support Pension.
- Create a more efficient Primary Health Care system which ensures improved health outcomes, more effective use and sustainability of the Medicare Benefits Scheme and the Pharmaceutical Benefits Scheme (Primary Care Health reform[2]) and better treatment for veterans.

Painaustralia's submission recommends opportunities for service improvement and integration and potential budget savings in all of these areas.

We focus on the health and economic benefits of applying community-based, best practice strategies to prevent and manage chronic pain – Australia's third most costly health burden[3], a leading cause of long-term disability [4] and a major cause of forced retirement from the workforce and lost productivity.[5]

It is widely accepted that big picture changes are required for the primary health care system to move away from funding mechanisms designed for episodic acute care towards mechanisms that encourage integrated chronic care and self-care. Our recommendations for chronic pain provide excellent examples of the health benefits and potential economic benefits of such a system.

We are well aware of the need for fiscal constraint. Therefore our priority recommendations aim to utilise and enhance the expertise of existing primary health care professionals and, through training, to equip them to better manage a widespread and very costly health problem.

We also recommend funding for consumer-driven initiatives to promote ongoing education and self-management strategies in the community, reducing reliance on health services including medication and hospital services.

These are key recommendations of the National Pain Strategy 2010[6] and the NSW Health State-wide Pain Management Plan 2012[7], currently being implemented through the NSW Agency for Clinical Innovation.[8] (See Figure 1)

What we are proposing (summary)

Proposal 1: Effective Pain Management Training (detail page 15)
Priority funding through the new Primary Health Networks (PHNs) for training for GPs, pharmacists, nurses and allied health professionals to enable them to more effectively prevent and manage chronic pain in the community/primary care/ aged care – especially in regional and rural areas and indigenous communities)[9,10] and avoid the unnecessary drain on hospital services.

Proposal 2: Development of Community-based GP-led Pain Teams (page 16)
Support for PHNs to develop appropriately trained GP-led, multidisciplinary teams (comprising a nurse, pharmacist, clinical psychologist, physiotherapist – or other allied health professional) to work collaboratively to more effectively manage chronic pain conditions in the community, building on the training provided (as above).

Proposal 3: An MBS Item Number for Chronic Pain (page 17)
A new MBS item number for chronic pain that enables extended consultations with specially trained allied health professionals as referred by the patient's GP. This would combine the existing Chronic Disease Management Plan and Better Access to Mental Health Care Initiative.

Proposal 4: Integrated Pain Health Pathways (page 18)
Development of integrated linkages between primary, secondary and tertiary facilities to ensure appropriate referral, use, and timely access to pain services through Health Pathways (or similar).

Proposal 5: Community Support and Help Line (page 18)
Providing funding to the Australian Pain Management Association (APMA) for the national expansion of community support groups to foster peer support, including an urgently needed Help Line, and ongoing consumer education around self-management of chronic pain.

Proposal 6: Engaging Pharmacists in Community Support and Education (page 19)
Pro-active engagement of community pharmacists (through the Pharmacy Guild and the PHNs) and in collaboration with GP led teams, to provide patient/consumer education about chronic pain, self-management strategies and Quality Use of Medicines (including opioids and other frequently over-used or misused medications). Such initiatives to be aligned with and supported by NPS Medicine- wise activities and programs.

Proposal 7: Implementation of ERRCD System (page 20)
The national implementation of the Electronic Recording and Reporting of Controlled Drugs (ERRCD) as advocated by the RACP, the RACGP, the Pharmacy Guild and other professional bodies concerned about inappropriate use of opioids and other prescription medications.

Proposal 8: Implementation of ePPOC (page 21)
The national Implementation of the Electronic Persistent Pain Outcomes Collaboration ePPOC) to collect, evaluate and report on the effectiveness of pain programs as the basis for continuous improvement.

EVIDENCE INCLUDING HEALTH BENEFITS AND COST SAVINGS TO SUPPORT THESE RECOMMENDATIONS

In the workplace (supports proposals 1, 2 and 3)

Significant health benefits and cost savings were clearly demonstrated in a workplace setting in an early intervention study to identify and better manage injured health workers at high risk of delayed return to the workforce due to chronic pain. The trial, conducted at Concord Hospital in NSW, identified injured workers most at risk of developing chronic pain and applied strategies to prevent this at an early stage after injury.[11]

There were savings of 25% in the high risk group in terms of reduced health and compensation costs as a consequence of significantly improved return to work rates. See Table 1 below.

TABLE 1.

Results of Concord Hospital injured health workers Workcover Trial

Number and costs according to risk category of injured worker.

RISK CATEGORY	NUMBER (%)	NUMBER (%)	$ COST	$ COST
	NON-INTERVENTION GROUP (Phase I)	INTERVENTION GROUP (Phase II)	NON-INTERVENTION GROUP (Phase I)	INTERVENTION GROUP (Phase II)
LOW	36 (47%)	40 (51%)	$4,898	$4,898
MEDIUM	24 (31%)	23 (29%)	$6,752	$6,752
HIGH	17 (22%)	15 (19%)	**$17,178**	**$12,847 Difference of $4,331 or 25%**

These findings have led the NSW State Government to commission a major state-wide trial currently under way, to further evaluate the broad application of the Concord protocol.

The trial is being conducted with injured hospital workers in NSW and is funded by a consortium comprising SiCorp, NSW Ministry of Health and EML Insurance, under the guidance of researchers from the University of Sydney. This is the first major controlled trial of early intervention for workers with soft tissue injuries and the results will be available later in 2015.

In the community (supports proposals 1 and 2)

In Western Australia, Perth North Medicare Local has been operating the STEPS (Self Training Educative Pain Sessions) program based on a pre-clinic model originally developed by the Fremantle Hospital Pain Medicine Unit.

Participants in the pre-clinic program reported significantly improved health outcomes with reduced reliance on medication.[12]

Data from the Fremantle Hospital STEPS pre-clinic program shows significant reduction in wait times and costs at public pain medicine units in Perth and increased use of active pain management (self-care) strategies and patient satisfaction.[13]

- Clinic 1 – wait times reduced from 105.6 weeks to 16.1 weeks
- Clinic 2 – wait times reduced from 37.3 weeks to 15.2 weeks
- Unit costs per patient reduced from $1805 (in public hospital unit) to $541 (in STEPS pre-clinic program)
- Less than half (48%) of patients requested referrals to tertiary centres after participating in STEPS; while 52% chose to utilise self- care or co-care with community based health professionals

The community program now run by Perth North Medicare Local is also reporting significantly improved patient outcomes. The cost per individual of this program ranges from $1100 – $1500 depending on numbers participating – still significantly less costly than the hospital based program.

A similar multidisciplinary model of care is also being trialled though the NSW Central Coast Medicare Local and data from this will be available later this year.[14]

In tertiary care (supports proposals 1 and 2)

The ADAPT multidisciplinary program run by the Pain Management Research Centre at Royal North Shore Hospital is a high intensity 3 week program. Results of this program are an indicator of what can be achieved with similar, but lower intensity primary care programs. Health Outcomes and Cost Savings from this program are summarised below:[15]

AFTER ADAPT

1. Rehabilitation

- 92% of patients completed the 3-week hospital phase (ie. 40 hours a week)
- 80% on no medication after ADAPT (much reduced in the rest)
- 75% not significantly disabled by pain after ADAPT
- At long-term follow-up (3-4 years), 71% of patients reported that pain was not precluding their ability to work (versus around only 38% in this category at admission).

Thus, following ADAPT, 75% show a capacity for at least part time work, or retraining.
Three + years later, 70% still say pain is not limiting their ability to work.

2. Depression

- 70% of patients have normal mood levels by 1-month after ADAPT
- Most maintain this improvement over the following 3-4 years

3. Pain severity

- Average pain ratings actually drop slightly, despite less medication and higher activity levels (which indicates that pain doesn't have to stop re-activation)
- 3-4 years later, average pain levels remain about the same

4. Working/retraining (Comparing patients at follow-up with their work status on admission to ADAPT)

- Working or retraining (in patients of working age and have worked before injury):
  - Before ADAPT: 30%
  - 6-months after ADAPT: 63%
  - 3-4 years after ADAPT: 66%

Result: 2 out of 3 patients are in some form of work within 6 months after ADAPT and most are still working in some capacity 3-4 years later.

In coordinated veterans' care

The Department of Veterans' Affairs (DVA) has incorporated access to improved methods of treating chronic pain into the Co-ordinated Veterans' Care program.[16]

The DVA recognises the frequent co-existence of chronic pain and post-traumatic stress disorder and the difficulties doctors confront in treating such patients, particularly younger veterans who potentially have a long and productive future provided they have access to effective care.

The DVA services also embrace community support for veterans with pain through the MATES program which provides community support and promotes self-care.

Data is being collected from these programs but is not yet available.

The DVA recognises that training is vital to enable health professionals to provide appropriate support from such patients.

> *"Patients with unresolved chronic pain are often angry, frustrated and very difficult for health care professionals to manage – especially if they have already seen other practitioners and tried a range of medications. They are desperate and feel they have lost all control.*
>
> *"The situation is compounded if the pain is associated with a mental health problem such as post-traumatic stress disorder."*
>
> *Dr Graeme Killer AO, Recently retired Principal Medical Adviser, Department of Veterans' Affairs.*

Summary

Given the widespread prevalence of chronic pain – one in five of the population and rising to one in three people over the age of 65 – we believe these early trials and established programs are very positive indicators of the benefits that could be derived from a national roll out of the proposed model of care through the new Primary Health Networks.

While more definitive data will be available later in 2015 at the completion of the NSW trials, there is a major opportunity for national leadership to address the growing issue of chronic pain, and its impact at the individual and national levels as the new Primary Health Networks begin planning their needs assessments and priorities. It is critical that chronic pain services are strongly represented.

We believe it is also vital to build on current initiatives so that momentum and benefits being achieved are not lost.

It is significant that all Australian state health departments and ACT Health have now adopted the recommendations of the National Pain Strategy and are taking steps to develop these primary care models as a component of an integrated state-wide plan. Where possible they are being assisted by tertiary pain centres in metropolitan and regional areas.

However progress is fragmented, under-funded and lacking national co-ordination. A great deal more could be achieved with a co-ordinated, strategic national approach.

Social and economic impact of chronic pain

Chronic pain – that is, pain that persists for three months or more, or longer than the normal time required for healing – is Australia's third most costly health condition, affecting one in five of the population including adolescents and children and one in three people over the age of 65. Five percent of people with chronic pain also report severe disability.[17]

Studies in other western nations show a similar or higher prevalence.[18] This points to an escalating and increasingly costly health problem with Australia's ageing population.

The 2010 Global Burden of Disease (GBD) Report reveals that back pain and other musculoskeletal problems both associated with chronic pain are among the leading causes of years lived with disability (disability-adjusted life years – DALYS) and represent a major cause of lost productivity.[19]

In 2005, the most recent year for which comparable prevalence data on all diseases are available, chronic pain prevalence was comparable to or higher than a number of National Health Priority Areas (NHPAs). Current NHPA conditions are: cardiovascular disease, cancer, musculoskeletal diseases, injuries, mental disorders, asthma and diabetes, with dementia added in 2014.[20]

Chronic pain is a factor in many of these conditions. However it is also now widely understood to be a chronic condition in its own right.[21] Indeed, the World Medical Association recognises chronic pain as a chronic disease.[22] Despite this, and the growing awareness of internationally recognised best practice strategies for preventing and managing chronic pain, Australia currently has no official national policy that addresses this serious and disabling health condition.

A 2007 Access Economics report in collaboration with the University of Sydney Pain Management Research Institute (PMRI) for MBF Foundation (now Bupa Health foundation) estimated the total cost of chronic pain at $34 billion a year including $7 billion in health care costs and $11.7 billion in lost productivity.[23] This equates to 36 million lost workdays per annum.[24]

The report estimated that half of these costs could be saved with the provision of timely, best practice pain management services.

Impact on productivity

Chronic pain (primarily persisting back pain, neck pain and other musculoskeletal problems) is the leading cause of long term disability in Australia (and internationally – see GBD study referred to above) and the major cause of forced workplace retirements leading to lost productivity, reduced taxation revenue and the need for welfare payments.[25,26]

Arthritis and back problems, both associated with chronic pain are the most common causes for people of working age (between 45 and 64) to drop out of the workforce, accounting for 40% of forced retirements – around 280,000 people in 2012. This has a significant impact on workplace productivity and Australia's economic health, with the lost workforce due to arthritis and back problems alone estimated to cost the economy over $4 billion a year in 2007.[27] Data from the USA reflect an even larger problem.[28]

The strong inter-relationship between health and economics is highlighted in a recent study by Schofield et al at Sydney University which reported: for arthritis alone, people on the Disability Support Pension forego $3-4 billion in income, and cost the government $290 million in social security payments, and almost $400 million in lost tax revenue.[29]

Co-existence of chronic pain with mental health disorders

The co-existence of chronic pain and mental health disorders is substantial in Australia, and in other countries. A 2010 AIHW report states in summary:[30]

- *Over 1.5 million people (10% of Australians aged 16-85 years) had at least one musculoskeletal condition and one mental disorder in the preceding 12 months.*
- *There were 470,000 more Australians who had both a musculoskeletal condition and a mental disorder in 2007 than would be expected if occurrences of the two conditions were independent of one another.*
- *Published studies suggest that causal pathways are more likely to be from musculoskeletal conditions to mental disorders than the reverse. Overall, in 2007, 5% of people with a musculoskeletal condition also had a mental disorder, the most common of which were anxiety disorders.*
- *The clear association between musculoskeletal conditions and mental disorders found in this study emphasises the need for health-care providers to be aware of and provide for a multidisciplinary approach to the management of this comorbidity.*

Link between chronic pain and suicide

Suicide Prevention Australia's 2012 report on Chronic Illness, Chronic Pain and Suicide (Chronic Pain and Suicide Prevention)[31] reports that 21% of people who died by suicide experienced physical health problems which may have contributed to their death.

People with chronic pain report high levels of suicide ideation, plans and attempts and their risk of death by suicide is twice that of non-pain controls.

Poor management of pain in residential aged care

Department of Health and Ageing data from 2012 show that 80 percent of people in residential aged care have persistent pain. However evidence suggests that pain is often under-treated or poorly treated in the elderly, especially among those living in residential aged care.[32]

A major contributor to poor management is the lack of resources and knowledge about effective multidisciplinary management of chronic pain. This is a particular issue in the case of people with dementia who have difficulty communicating their pain. Commonly, such people are either under-treated or over-treated, frequently with opioids or psychotropic medications rather than analgesics.[33]

Improved access to education and training about chronic pain and its management for aged care workers and primary health care professionals would be a first important step to help alleviate poor pain management practices in residential aged care. Studies also show that self-management strategies can be effective in older patients, reducing reliance on medication.[34]

A more effective model of care

As for all chronic conditions, the vast majority of people with chronic pain are best managed in the community or at primary care level with multidisciplinary pain programs and ongoing support for self-care. Specialist pain clinics in public hospitals can then be freed up to treat more complex patients and also provide training resources for primary and secondary care.[35]

People living with pain continue to face unacceptably long waiting times to access appropriate treatment at multidisciplinary pain clinics in public hospitals, inevitably contributing to escalating disability, excessive and potentially harmful levels of opioid prescribing and avoidable health costs.[36]

The advent of the National Pain Strategy in 2010 – and the subsequent adoption of its recommendations by all state governments and the ACT – is slowly starting to improve this situation. However much greater impetus is urgently needed if we are to avoid escalating disability and increasing harm, including addiction from inappropriate use of medication.

Investments by governments in Queensland, New South Wales and Victoria have enabled the expansion of pain services – initially available only in major metropolitan areas – into 14 regional centres on the east coast.

However the challenge for the health system as a whole is to create a more effective triage system for patients at the primary care level. This would prevent many people with persisting pain from ever needing to be referred to a tertiary service and enable the tertiary services to see the more disabled and complex patients in a more timely and effective manner.

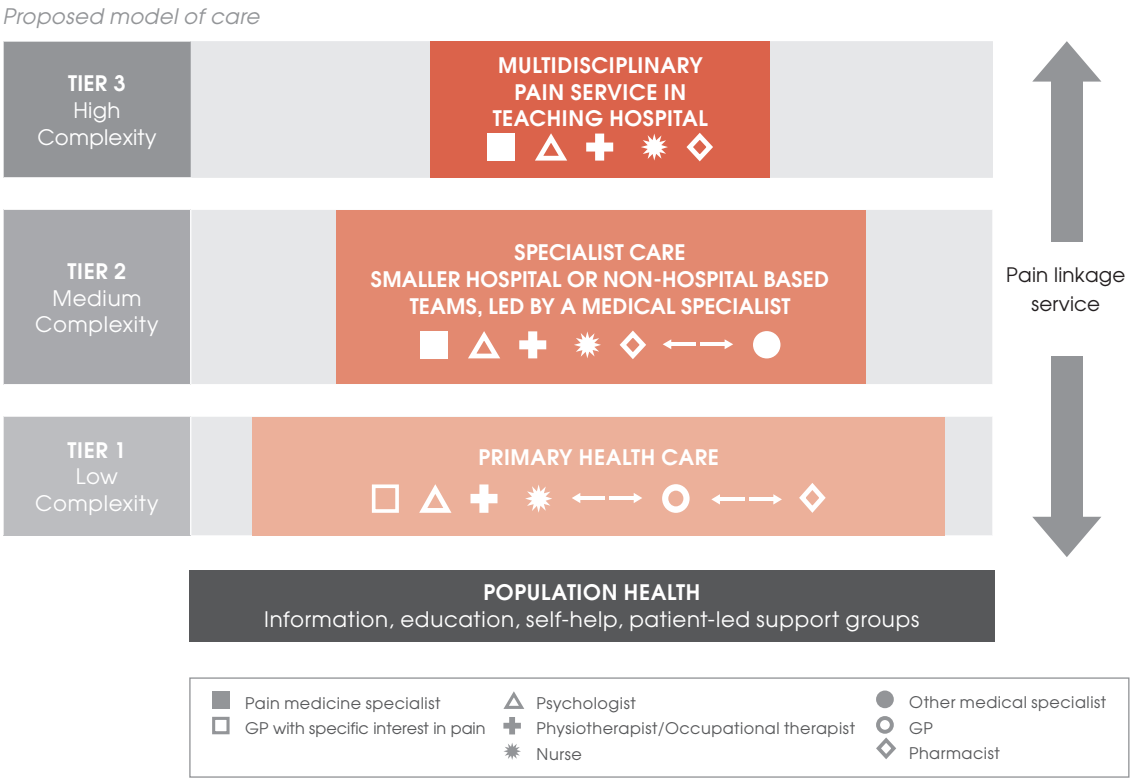
The National Pain Strategy recommends that people living with pain have access to community-based multidisciplinary pain services, ideally with a locus around their local GP. Primary care teams should be connected with and supported by specialist pain teams working in metropolitan and regional pain centres and have the option to refer more complex patients to these centres, as necessary.

Formalised group programs such as STEPS and the Central Coast Medicare Local Model have proven effectiveness and can be developed by the Primary Health Networks drawing upon the expertise of local, trained health professionals.

See Figure 1 on the following page.

FIGURE 1.

National Pain Strategy Model of Care



This recommended model aligns with a 2012 policy statement by the Royal Australian College of General Practitioners on "A Quality General Practice of the Future" (part of the RACGP Presidential Taskforce on Health Reform) which articulates this eloquently (p.2):[37]

General Practice:

- *"is based on flexible general practitioner led multidisciplinary teams in which all team members are supported to fully develop their clinical skills and potential*
- *"employs effective communication methods within and across clinical teams*
- *"delegates specified responsibilities for elements of care within the team according to known capabilities, with appropriate supervision, support and clinical governance processes"*

An urgent need to address the inappropriate prescribing of opioids and other medications

The increased prescribing of opioids over the past 10-15 years, primarily by doctors seeking to help people living with chronic pain is a widespread phenomenon without any adequate evidence base[38] in developed countries.[39] It is likely to be the result of:

a) Lack of education about alternative ways to treat and manage chronic pain.

b) Lack of the ability to refer patients because of the unacceptably long waiting times and poor access to multidisciplinary services, which can effectively treat and manage chronic pain.[40]

GPs who have had training in psychological therapies through the Pain Management Research Institute, University of Sydney training programs have reported they are now more confident in managing patients with chronic pain.

A survey of General Practitioners has shown that GPs with pain/addiction or psychology training were superior pain/opioid managers.[41]

Issues with opioids are compounded when, quite commonly, benzodiazepines and other psychotropic medications are prescribed inappropriately and can often lead to iatrogenic harm alongside opioid medications.[42]

> *"The 'gamebreaker' lies in the development of multidisciplinary teams of GPs, nurses, pharmacists and allied health professionals – all with training in pain management – capable of working in an interdisciplinary manner to assess and treat the complex physical, psychological and environmental factors in patients with chronic pain."*
>
> *Professor Michael Cousins AO, Chair National Pain Strategy, Medical Journal of Australia October 2014.*

Proposal 1: Effective pain management training

> Priority funding through the new Primary Health Networks for web-based interactive training for GPs, pharmacists, nurses and allied health professionals to enable them to establish effective chronic pain management services and more effectively prevent and manage chronic pain in the community/primary care/aged care - especially in regional and rural areas and indigenous communities).[43,44]

Access to web-based training

Basic online pain management education programs have been developed by the Faculty of Pain Medicine Australia New Zealand College of Anaesthetists (ANZCA), with joint private sector – federal government funding in 2013-14. These programs are now readily available online – at no cost or low cost – to GPs through the RACGP and to all primary health care professionals through the Faculty of Pain Medicine, ANZCA. Negotiations are currently occurring with various allied health colleges and professional bodies including those for nursing, pharmacy and physiotherapy, for CPD accreditation for the program.

However practical skills based training for all health disciplines dealing with patients who have persisting pain is also essential. In some areas, this may be provided locally if there is capacity and funding to do this, through links with tertiary services. However such training is necessarily restricted to a few small areas and where it is available at all, funding is limited.

A more efficient and consistent form of nationwide skills training is now available in a novel online format. This has been trialed across Australia since 2012 and has recently been funded by the NSW Motor Accidents Authority (NSW MAA) to expand its capacity to deliver a nationwide training program. The Pain Management Research Institute (PMRI), University of Sydney developed this webinar-based pain management training program in 2012, with the support of the NSW MAA.

In 2013 this program received additional funding from the private sector and the federal Department of Health. Health professionals from over half of the Medicare Locals across the country applied to undertake the training. While this initial funding made it possible for around 80 health care professionals to undergo this training, there are still around 100 on the waiting list and funds have been exhausted.

It is strongly recommended that this activity is built on by the new PHNs, with strategic direction from the federal Department of Health.

Cost of proposal:

We recommend an average allocation of $300,000 for each of 30 PHNs over three years for training. That is a total of $9million over three years. The funding to be managed by the PHNs, would be used to cover management/facilitation/delivery of training (PMRI) and coordination/facilitation by PHN's and Painaustralia.

It is anticipated that PHNs and Local Health Districts will then be able to sustain their operations with locally trained personnel and recurrent funding/staffing.

There will be no development costs required for training as quality, best practice programs have already been developed.

Proposal 2: Development of community-based GP-led pain teams

Support PHNs to facilitate the development of appropriately trained GP-led, multidisciplinary teams (comprising a nurse, pharmacist, clinical psychologist, physiotherapist – or other allied health professional) to work collaboratively to more effectively manage chronic pain conditions in the community – building on the training provided – as above. In areas where tertiary pain services are available, such teams would liaise with and also seek direction and support from these services (see point 5 below).

With the required training, primary care teams will be equipped to work collaboratively to provide care to individual chronic pain patients. Effectiveness will be greatly enhanced by promoting use of Personal Electronic Health Records system by patients and multidisciplinary teams.

However the opportunity also exists for PHNs to draw upon trained personnel to develop low intensity group pain programs similar to the PNML STEPS and Central Coast Medicare Local models. This would require clinical and management leadership from PHNs as well as resources and funding. It is anticipated core or flexible funding may be used for this purpose.

Cost of community pain programs:

Indicative costs may be drawn from the PNML STEPS program and the Central Coast Medicare Local pain program. These are 6-week low-intensity group programs which provide individual assessments and consultations as well group education and training in self-management strategies.

Participant costs for individuals in these programs range from $1100-$1500 depending on numbers enrolled, which impacts on average overheads and on-costs.

Perth North has allocated $300,000 for 2014/15 for the STEPS programs (reduced from initial annual budget of $500,000 following ML grants cutbacks). This smaller allocation has been adequate to meet demand at this Medicare Local.

However, given that the Primary Health Networks will be on average twice the population catchment size of MLs, and demand is likely to be at a similar level, then it would be more realistic to allocate $ 500,000 per PHN. If all PHNs are to take this up, it would provide access to between 12,500 and 13,600 people with chronic pain nationally.

The data outlined earlier (p. 5 – 7 of this submission) are indicative of the savings that can be anticipated from such programs in terms of reduced hospitalisation, invasive surgical costs and medication consumption. However further economic evaluation of the model of care will require additional funding.

> *"Every GP we visited told us there was nothing wrong with our eight year-old daughter, Isabella, yet she was on crutches from the moment of her injury, and in excruciating pain.*
>
> *Her foot was purple and cold, and tilted on an angle. She refused to wear long pants or skirts because they would cause pain. Even a brush of wind would cause pain.*
>
> *It was three months before she was eventually diagnosed with Complex Regional Pain Syndrome and finally found help through a pain management program in north Queensland."*
>
> *Shay Linton, Queensland*

Proposal 3: An MBS item number for chronic pain

An MBS item number for chronic pain, which combines the current Chronic Disease Management Plan (five allied health visits) with a Better Access to Mental Health Plan (10 allied health visits) as referred by the patient's GP and available only to health professionals who have undertaken accredited education and training in pain management.

Painaustralia has proposed a trial to evaluate this concept in collaboration with the Pain Management Research institute, University of Sydney with evaluation by University of Sydney Health Economics experts. The initial concept was presented to Federal Treasury and Department of Health and to the National Disability Insurance Agency. We would value the opportunity for further dialogue about this proposal.[45] (see budget for this on page 24)

Proposal 4: Integrated Pain Health Pathways

Development of integrated linkages between primary, secondary and tertiary facilitiesto ensure effective triage for patients allowing appropriate referral, use, and timely access to pain management services through Pain Health Pathways. Refer: hne.healthpathways.org.au.

A number of Medicare Locals have started to develop chronic pain Health Pathways and it is expected that this will continue under the new PHNs. However, there is considerable variability in this activity across the country. Yet, the NSW health survey[46] found that chronic, disabling pain was represented across all regions of NSW, and it can be expected that this is the case across the country generally.

With respect to the Department of Health's Outcome Statements it is crucial that the Commonwealth demonstrate strategic leadership in working with all jurisdictions to ensure integrated chronic pain management linkages are established and adequately resourced. Teams can be 'virtual' (e.g. using electronic communications), as long as there is a clear commitment to team-based care, coordinated by general practice, in which all parties are linked electronically.

Proposal 5: Community support and help line

Funding for the national expansion of community support groups to be developed and managed under the direction of the Australian Pain Management Association (APMA) to foster peer support , including an urgently needed Help Line and ongoing education about self-management of chronic pain, to avoid relapse and over-reliance on health services including medication.

It has been demonstrated for a significant number of chronic disease issues that local support groups add a measurable benefit to consumer outcomes. Alzheimer's Australia[47]; Diabetes Australia; Cancer Australia; Arthritis Australia are examples.

APMA currently manages a network of peer support groups for people with chronic pain – including a frequently accessed Help Line. These are maintained by volunteers supported by small community donations. Such services are clearly not sustainable without dedicated funding and cannot hope to optimise outcomes and best practice standards.

The APMA Help Line:

- Offers a frontline service providing callers (patients, family, carers and health professionals) with information and practical support on chronic pain, with a focus on non-pharmacological management options. Many callers have problems managing medication or suffer anxiety and depression.
- It is the only telephone Help Line in Australia covering all chronic pain conditions including the recently diagnosed and the older age group.
- Provides specific support for back pain, the leading cause of disability in Australia, impacting greatly on middle aged and older Australians. 3 million Australians (13.6% of the population) have back and neck problems.

Cost of proposal:

Costs are summarised below, with detailed costings available as required.

Establishment of 20 new peer support groups and cost for 16 ongoing groups including administration, venue hire, honoraria, equipment and materials, community activities and events, advertising and promotion.	$263,000
Weekend skills training for facilitators (based on 72) and supervisor training (3 supervisors) including administration, venue hire, materials, training manuals, consultants fees catering, travel and accommodation.	$40,000
Project Management, fundraising, communication costs.	$72,000
Establishment and Maintenance of Help Line	17 (22%)
TOTAL BUDGET	**$625,000**

The budget is commensurate with other community support and phone Help Lines.

Proposal 6: Engaging pharmacists in community support and education

Proactive engagement of community pharmacists (through the PHNs, and the Pharmacy Guild of Australia) and in collaboration with the GP-led teams to provide consumer education about chronic pain and effective self-management strategies, Quality Use of Medicines and management of medications (including opioids and other frequently over-used or misused medications). Such initiatives to be aligned with and supported by NPS Medicinewise programs and activities.

Emphasis should be placed on utilising and enhancing the expertise of existing health professionals. As primary health care providers, community pharmacists are involved in health promotion, early intervention, prevention, assessment and general health management, often being the first point of contact between the public and the health care system, with more than 400,000 people visiting Australia's 5,400 community pharmacies each day. Community pharmacy offers a highly accessible network of primary health care professionals who provide quality advice and professional services, often over extended hours seven days a week in urban, rural and remote areas.

A result of chronic pain is often complicated medicines regimes involving polypharmacy (five or more medicines), noting that the more medicines a person is required to take, the higher the risk of medicine misadventure and hospitalisation.[48] Each person experiences different circumstances, abilities, needs and resources as a result of chronic pain. The availability of personalised medication and health management services through a locally based, highly accessible community pharmacy is an advantageous move towards filling a gap between heavily relied-upon government provided services and high-cost private care options. 94% of Australians reported using a pharmacy in 2012, with 85% expressing satisfaction with the service, the highest of all the major health care providers.[49]

Proposal 7: Implementation of ERRCD system

We recommend the national implementation of the Electronic Recording and Reporting of Controlled Drugs (ERRCD) system, as also advocated by the RACGP, the Faculty of Pain Medicine ANZCA, the RACP and the Pharmacy Guild.[50]

There is increasing understanding of the lack of evidence for the effectiveness of long-term use of opioids to manage chronic pain and growing evidence of the harm associated with their use. Despite this, there has been a dramatic increase in their rate of prescription over the past 15 years.[51,52]

A move from manual to electronic recording and real-time reporting will improve the ability to efficiently monitor the prescribing and dispensing of Controlled Drugs to help ensure appropriate access to these medicines.

This process can be expected to help detect overuse and inappropriate use of opioids, allowing such patients to be directed towards replacement therapies or non-pharmacological strategies to manage chronic pain. There is now good evidence that pain management programs using cognitive behavioural therapy (CBT) methods can be very effective in weaning people off opioids and other medications.[53] Active therapies including exercise and meditation strategies can help maintain a reduction in drug use, a concept supported by the Royal Australasian College of Physicians (RACP).[54]

The ERRCD system will assist state and territory health departments to manage approvals for Controlled Drug prescribing and is not intended to present a barrier to consumers accessing Controlled Drugs for legitimate health purposes.

Cost of proposal:

The previous Government had committed $5 million to implement ERRCD. However, it is anticipated that more sustainable funding will be required if a national rollout is to be effective.

Proposal 8: Implementation of ePPOC

To ensure continuous evaluation and improvement of pain management programs, we recommend immediate funding for all tertiary pain clinics and primary care pain services to participate in the collection and evaluation of data through the Electronic Persistent Pain Outcomes Collaboration ePPOC, currently managed by Wollongong University. As a second stage, we recommend that data is also collected and evaluated from primary care programs.

ePPOC is already collecting, evaluating and reporting on data collected from almost 30 tertiary pain clinics in Australia. The data will be used to measure outcomes, identify best practice protocols, set benchmarks for performance and identify variation in treatment and outcomes across the participating services. At present however, funding for this important initiative is time-limited, provided by a small number of state governments (primarily NSW) and only available to specialist tertiary pain management services.

Cost of proposal:

A proposal requesting funding to allow all Australian publically-funded tertiary pain services to participate in ePPOC has been presented to the Standing Council on Health and the previous Minister for Health, the Hon Peter Dutton. This proposal recommended that the cost of national implementation of ePPOC ($780,000 p.a.) be shared between federal and state health departments according to the AHMAC cost sharing formula. To date, the proposal has received in-principle support and a final decision by AHMAC is expected this year. We recommend adoption of this proposal by AHMAC.

There is currently no funding for primary care pain services to participate in this quality assurance initiative, making it difficult to monitor and compare patient outcomes and service delivery in these services. It is hoped that as a second stage of the rollout of the ePPOC, funding to evaluate primary care services can be added.

The additional cost for participation by the 30 Primary Health Networks would be $150,000 per annum. This expansion of scope would ensure that all units providing pain management services participate in a quality assurance program, allowing evaluation and monitoring of treatment outcomes and efficient use of funding to support people experiencing chronic pain.

TIMEFRAME

A number of pain management and prevention activities are already underway at state level and through Medicare Locals (transitioning to PHNs.) It is crucial that Primary Health Networks are provided with both clarity of purpose and funding to continue and expand on these current activities. As the Primary Health Networks are rolled out from July 2015, we recommend that part of their remit be to implement a National Pain Management Program with a built-in evaluation component.

We recommend funding for our priority recommendations be allocated progressively from 1 July 2015 and that a multi-year commitment be made to achieve longer-term outcomes.

Steps required

1. Development of national pain management strategic plan which would involve consultation with all stakeholders and draw substantially on the National Pain Strategy 2010 and the NSW State-wide Pain Management Plan 2012. It would also map and embrace other existing state-based and community initiatives.
2. Implementation of training in pain management for primary health professionals and evaluation of benefits of this.
3. National expansion of community support groups and the establishment of a community Help Line, with appropriate evaluation and reporting.
4. Immediate expansion of the ePPOC to collect data from all publicly funded tertiary pain clinics.
5. Development of primary care pain programs with evaluation through the ePPOC to ensure accountability, effectiveness and continuous improvement.
6. Ideally the national program would be supported by a community awareness campaign, which comprises integrated communications strategies including paid advertising. Acknowledging current cost constraints, we hope this can be considered in due course when funding can be made available.

BUDGET SUMMARY

Priority Recommendations:	Year 1	Year 2	Year 3	Total
Webinar based training through 30 PHNs (proposal 1)	$3,000,000	$3,000,000	$3,000,000	**$9,000,000**
Community Support Groups	$375,000	$200,000	$200,000	**$775,000**
Community Help Line	$250,000	$150,000	$150,000	**$550,000**
ePPOC	$780,000*	$780,000*	$780,000*	**$2,340,000**
ERRCD	$5,000,000	$5,000,000	$5,000,000	**$15,000,000**
Totals	$9,405,000	$9,130,000	$9,130,000	**$27,665,000**
Second Stage Recommendations:	**Year 1**	**Year 2**	**Year 3**	**Total**
Primary care pain programs $300,000 for each PHN to run up to 10 programs a year	$9,000,000	$9,000,000	$9,000,000	**$27,000,000**

*To be shared with the states.

Budget for trial to evaluate health outcomes and associated economic benefits of implementing community-based best-practice pain management programs.

Aim: To evaluate the health and economic benefits of providing support for a best-practice model of care, including Allied Health workers (mainly physiotherapists and psychologists) to treat patients with chronic musculoskeletal pain conditions (e.g., back, neck, arthritis) in the community (primary care level) in a planned, multidisciplinary intervention coordinated by the patients' GPs, with the assistance of their practice nurses.

ESTIMATED PROJECT COSTS	
Research Manager Full time for three years; salary plus on-costs	$405,000
Statistician	$80,000
Health economist	$170,000
SUPPORT/INFRASTRUCTURE	
Data entry	$25,000
Computer and software	$4,000
Travel	$14,000
Office expenses (e.g. stationery/photocopying)	$2,000
Training for allied health (10 participants from 5 states)	$35,620
Participant liaison and facilitation	$30,000
TOTALS	**$765,620**

SUPPORT FOR PROPOSAL

Painaustralia member organisations include:

- The Faculty of Pain Medicine, Australia New Zealand College of Anaesthetists (ANZCA)
- The Australia Pain Society
- The Australian Pain Management Association
- Chronic Pain Australia
- Pain Management Research Institute, University of Sydney
- The Pharmacy Guild of Australia

The proposal aligns with The Royal Australasian College of Physicians, RACGP, Faculty of Pain Medicine-ANZCA and Royal Australia New Zealand College of Psychiatrists policy statement on **Improving clinical management chronic non-malignant pain (CNMP),** which includes the following (p.6):

1. *Strategies to optimise treatment of CNMP and minimise harms from pharmaceutical opioids include improved and integrated primary care and specialist services for managing CNMP.*
2. *Strategies for improving management of CNMP must recognise the essential role of general practitioners, facilitate the provision of multidisciplinary services at the primary care level, and enhance access to specialist pain and addiction medicine services.*
3. *Multidisciplinary models of care, both in primary and specialist settings are important to optimise pharmacological and non-pharmacological management of CNMP.*
4. *There is currently a substantial unmet need in the population with CNMP for services specialising in pain medicine and addiction medicine.*

The Australian Medical Association 2010 Position Statement on Primary Health Care includes the following:[55]

> *5.16 For the primary care team model to be successful, strong communication channels between general practitioners, pharmacists, allied health providers, community nurses, general practice nurses and specialists must be developed and maintained. These channels must allow GPs to provide information to all professionals involved in the care of the patient and receive timely reports from each of these providers.*

ENDNOTES

[1] http://www.budget.gov.au/2014-15/content/bp1/html/bp1_bst1-03.htm
2014-15 Federal Budget Statement 1: Fiscal Strategy and Outlook
The medium term fiscal strategy of achieving budget surpluses, on average, over the course of the economic cycle is underpinned by the Government's objectives to: invest in a stronger economy by redirecting Government spending to quality investment to boost productivity and workforce participation

[2] http://www.health.gov.au/internet/main/publishing.nsf/Content/H1415G004
Primary Health Networks are being established with the key objectives of:
- increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- improving coordination of care to ensure patients receive the right care in the right place at the right time.

[3] http://www.painaustralia.org.au/images/pain_australia/MBF%20Economic%20Impact.pdf

[4] Blyth FM, et al, Chronic pain in Australia: a prevalence study, Pain 89 (2001) 127-134

[5] The most common reasons for people of working age to drop out of the workforce are back problems and arthritis – both associated with chronic pain – accounting for around 40% of forced retirements.
Schofield DJ, et al (2012) Quantifying the productivity impacts of poor health and health interventions. *Medicines Australia Conference 2012: Living longer, living well. Session: Prolonging participation and promoting productivity: How do we quantify and better demonstrate the benefits of medicines for the longer term?,* October 2012, Sydney

[6] http://www.painaustralia.org.au/the-national-pain-strategy/national-pain-strategy.html

[7] http://www.health.nsw.gov.au/PainManagement/Pages/government-response-taskforce-report.aspx

[8] http://www.aci.health.nsw.gov.au/networks/pain-management

[9] National Rural Health Alliance: Chronic Pain a Major Issue in Rural Australia, Oct 2013
http://ruralhealth.org.au/sites/default/files/publications//nrha-factsheet-pain.pdf

[10] Refer previous work by Painaustralia with 31 Medicare Locals as reported in National Pain Strategy Review 2014:
http://www.painaustralia.org.au/component/content/category/83-our-strategy.html

[11] (Pearce G, McGarity A, Nicholas MK, et al. Better outcomes in worker's compensation through very early selective intervention. Paper presented at: Combined Annual Scientific Meeting of the Australasian Faculty of Occupational and Environmental Medicine, and Australasian Faculty of Rehabilitation Medicine; May 2008; Adelaide, Australia.)

[12] Self-Training Educative Pain Sessions (STEPS) report prepared by Perth North Medicare Local June 2013;
(also program outcome data to be presented at APS scientific conference in March 2015)

[13] Small STEPS, big strides for those in pain, *Medical Forum,* 2012

[14] http://www.ccnswml.com.au/programs-services/pain-management/pain-management-update

[15] ADAPT for work related pain: Intensive cognitive-behavioural pain management program Pain Management & Research Centre (University of Sydney/Royal North Shore Hospital) – 2005
http://www.painaustralia.org.au/images/pain_australia/ADAPT-Work-related-pain-2005.pdf

[16] https://cvcprogram.flinders.edu.au/

[17] Blyth FM op. cit.

[18] Johannes CB et al, The Prevalence of Chronic Pain in United States Adults: Results of an Internet-Based Survey J. Pain, November 2010 Volume 11, Issue 11, Pages 1230–1239

[19] http://www.healthdata.org/sites/default/files/files/country_profiles/GBD/ihme_gbd_country_report_australia.pdf

[20] Australian Bureau of Statistics (ABS) National Health Survey (NHS) 2004-05

[21] European Pain Federation Declaration on Pain: http://www.efic.org/index.asp?sub=724B97A2EjBu1C

[22] World Medical Association Resolution 2011 http://www.wma.net/en/30publications/10policies/p2/

[23] http://www.painaustralia.org.au/images/pain_australia/MBF%20Economic%20Impact.pdf

[24] There were estimated to be 9.9 million workdays absent due to chronic pain annually in Australia, equating to a cost of AUD 1.4 billion per annum. Under the assumption that reduced-effectiveness workdays affect productivity costs in the same way as lost work days, **the total number of lost workday equivalents was 36.5 million, with the total annual cost of lost productivity due to chronic pain estimated as AUD 5.1 billion per annum.**
(Van Leeuwen MT, Blyth FM, Nicholas MK, Cousins MJ, Chronic pain and reduced work effectiveness: the hidden cost to Australian employers, Eur J Pain 2006 Feb;10(2):161-6)

[25] National Pain Strategy – Painaustralia 2010
http://www.painaustralia.org.au/the-national-pain-strategy/national-pain-strategy.html

[26] Schofield DJ et al 2012 op. cit.

[27] Painful Realities: The economic impact of arthritis in Australia in 2007
http://www.arthritisaustralia.com.au/images/stories/documents/reports/2011_updates/painful%20realities%20report%20access%20economics.pdf

[28] http://annals.org/article.aspx?articleid=2089371 – Position Paper January 2015
Chronic pain affects an estimated 100 million Americans, or one third of the U.S. population. Approximately 25 million have moderate to severe chronic pain that limits activities and diminishes quality of life. Pain is the primary reason that Americans receive disability insurance, and societal costs are estimated at between $560 billion and $630 billion per year due to missed workdays and medical expenses.

[29] Schofield DJ et al 2012 op. cit.

[30] http://aihw.gov.au/publication-detail/?id=6442468392&tab=2

[31] http://suicidepreventionaust.org/wp-content/uploads/2012/05/SPA-PositionStatement-April_2012_Final-V4.pdf

[32] Gibson S. Improvement of Pain Management in Residential Aged Care, Issues Paper

[33] mja.com.au/journal 2013/198/2/rethinking-psychotropics-nursing-homes

[34] M.N.Nicholas et al 2014.

[35] http://www.painaustralia.org.au/the-national-pain-strategy/national-pain-strategy.html

[36] Semple TJ, Hogg MN. Waiting in pain [editorial]. Med J Aust 2012; 196:372-373.
Lynch ME, Campbell F, Clark AJ, et al. A systematic review of the effect of waiting for treatment for chronic pain. Pain 2008; 136: 97-116

[37] http://www.racgp.org.au/download/Documents/Policies/Health%20systems/quality-general-practice-of-the-future-2012.pdf

[38] http://www.racgp.org.au/afp/2013/march/opioid-use-part-1/

[39] http://annals.org/article.aspx?articleid=2089371 USA National Institutes of Health: Pathways to Prevention – The Role of Opioids in the Treatment of Chronic Pain

[40] Semple TJ & Hogg MN, Waiting in Pain: Innovative approaches can give more Australians access to pain management, Medical J. Aust., 196 (6) April 2012

[41] Holliday S et al, An Evaluation of the Prescription of Opioids for Chronic Non-malignant Pain by Australian General Practitioners, Pain Medicine, 14:1,62–74, January 2013
http://onlinelibrary.wiley.com/doi/10.1111/j.1526-4637.2012.01527.x/abstract

[42] Polydrug abuse: a review of opioid and benzodiazepine combination use JD Jones, S Mogali, SD Comer – Drug and alcohol dependence, 2012 – ElsevierThe sources of pharmaceuticals for problematic users of benzodiazepines and prescription opioids Suzanne Nielsen, Raimondo Bruno, Louisa Degenhardt, Mark A Stoove, Jane A Fischer, Susan J Carruthers and Nicholas Lintzeris
https://www.mja.com.au/journal/2013/199/10/sources-pharmaceuticals-problematic-users-benzodiazepines-and-prescription

[43] Refer previous work by Painaustralia with 31 Medicare Locals as reported in National Pain Strategy Review 2014:
http://www.painaustralia.org.au/component/content/category/83-our-strategy.html

[44] National Rural Health Alliance, op. cit.

[45] M Nicholas, D Schofield, FM Blyth – Trial Proposal 29 April 2014 Community-based Best practice Pain Management, Better Health Outcomes and Associated Economic Benefits

[46] Blyth FM op. cit.

[47] Various reports can be accessed from this webpage: https://nsw.fightdementia.org.au/research-and-publications/reports-and-publications/other-papers-and-evaluations/evaluation-reports

[48] National Prescribing Service (June 2009) "Medication Safety in the Community: A Review of the Literature"

[49] Menzies-Nous (2012) Australian Health Survey Report

[50] The Electronic Recording and Reporting of Controlled Drugs (ERRCD) initiative will see the development and implementation of software programs that will provide:
- a nationally consistent Controlled Drug Electronic Register;
- a nationally consistent electronic system to collect and report data relating to the dispensing of Controlled Drugs; and
- real-time access for prescribers and pharmacists to current information on dispensing events for Controlled Drugs

[51] http://www.racgp.org.au/afp/2013/march/opioid-use-part-1/
http://www.racgp.org.au/afp/2013/march/opioid-use-part-2/

[52] http://www.hnehealth.nsw.gov.au/__data/assets/pdf_file/0007/76039/Reconsidering_opioid_therapy_May_2014.pdf

[53] ADAPT for work related pain: Intensive cognitive-behavioural pain management program Pain Management & Research Centre (University of Sydney/Royal North Shore Hospital) – 2005
http://www.painaustralia.org.au/images/pain_australia/ADAPT-Work-related-pain-2005.pdf

[54] The Royal Australasian College of Physicians: Prescription Opioid Policy: Improving management of chronic non-malignant pain and prevention of problems associated with prescription opioid use, 2009
http://www.racp.edu.au/index.cfm?objectid=D7FAA946-ACEE-2637-428D447EE5E581C3

[55] https://ama.com.au/position-statement/primary-health-care-2010

Contact Details: Lesley Brydon
Chief Executive Officer
Painaustralia
PO Box 3277 Tamarama NSW 2026
M: 0413 990 991
E: lesley.brydon@painaustralia.org.au
www.painaustralia.org.au

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