painaustralia

SENATE INQUIRY ON CURRENT BARRIERS TO PATIENT ACCESS TO MEDICINAL CANNABIS IN AUSTRALIA

FEBRUARY 2020

SENATE INQUIRY ON CURRENT BARRIERS TO PATIENT ACCESS TO MEDICINAL CANNABIS IN AUSTRALIA

Painaustralia is pleased to provide a submission to the Senate Inquiry on current barriers to patient access to medicinal cannabis in Australia.

Painaustralia is the national peak body working to improve the quality of life of people living with pain, their families and carers, and to minimise the social and economic burden of pain. Members include pain and other specialists, health practitioners, health groups, consumers and researchers. Painaustralia works with our network to inform practical and strategic solutions to address this complex and widespread issue.

THE ISSUE

The majority of people who seek medicinal cannabis do so for pain management, and there is growing interest and expectation around the use of these products to treat a range of conditions.[1]

This may be due to increased awareness and availability of medicinal cannabis, the recent establishment of a regulatory framework for these products, and interest in seeking out alternatives to opioids and other pain medications.

Painaustralia's acknowledges the widespread use of cannabis products and degree of community support for greater access to medicinal cannabis for a range of reasons. This situation highlights the significant gaps in access to, and understanding of, best practice pain management amid a rising pain burden.

BACKGROUND

The growing prevalence and cost of pain

Painaustralia's report, The Cost of Pain in Australia by Deloitte Access Economics, provides the most comprehensive analysis of the financial impact of chronic pain in Australia. It shows that chronic pain affects more than 3.37 million Australians. Chronic pain, also called persistent pain, is pain that continues for more than three months after surgery, an injury, as a result of disease, or from another cause.

For those who experience chronic pain, the pain can be debilitating and have an adverse effect on work, sleep, and relationships. Individuals with chronic pain may also commonly experience comorbidities such as depression, sleep disturbance and fatigue.

These comorbidities often contribute to worse health, societal and financial outcomes – for example, major depression in people with chronic pain is associated with reduced functioning, poorer treatment response, and increased health care costs. Nearly 1.45 million people in pain also live with depression and anxiety. Painaustralia's new report finds that the reported comorbidity for chronic pain and depression or anxiety is estimated at 44.6% of patients, which is within the range of estimated values from the international literature.[2]

The consequences of these gaps are immense. The price paid by people with chronic pain is continued physical and psychological ill health, social exclusion and financial disadvantage. Opioids continue to be over-prescribed for pain, with unacceptable consequences including dependency and opioid-related deaths.

Society as a whole pays the price too. The total financial costs associated with chronic pain were estimated to be $73.2 billion in 2018, which equates to $22,588 per person with chronic pain.[3]

More than 68% of people living with chronic pain are of working age. Without action, the prevalence of chronic pain will increase to 5.23 million Australians (16.9%) by 2050.

In 2018, the staggering cost of chronic pain to taxpayers (including quality of life) was $139 billion. This was on top of the fact that last year alone, Australians paid $2.7 billion in out of pocket expenses to manage their pain, with costs to the health system in excess of $12 billion.

WITH THE TRUE COST OF PAIN IN AUSTRALIA EXPOSED, ACTION IS URGENT

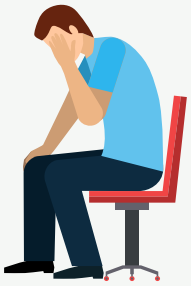
painaustralia

Millions of aussies in chronic pain are overlooked as they fall through the gaps of our health system, and struggle day-to-day, while costing the nation billions.

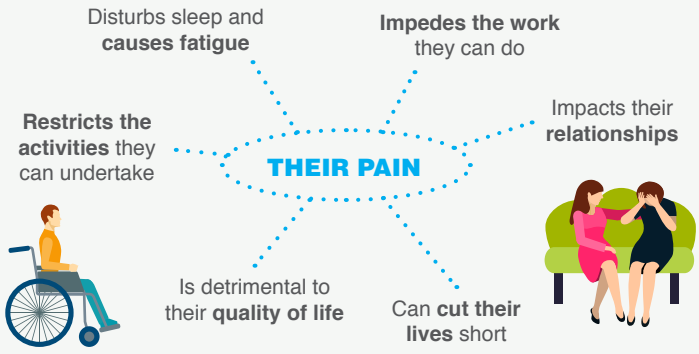
Chronic pain impacts the physical, mental & emotional wellbeing of millions:

44.6%
also live with depression and anxiery

increasing to over **2.33M** **by 2050**



In 2018, approximately 3.24 million Australians lived with chronic pain; this is set to rise to 5.23 million by 2050. 68.3% are of working age.



As the population ages, the burden of chronic pain only increases as will the billion dollar hit to an individuals back pocket and the economy:

$73.2b **in 2018 comprising of:**

equating to $22,588 per person

$12.2b **Health System costs**

$48.3b **Productivity losses**

$12.7b **Informal care, aids, deadweight losses**

If action is not taken, the annual cost of chronic pain in Australia will rise from $139.3 billion in 2018 to an estimated $215.6 billion by 2050*.

$66.1b **Reduction in quality of life**

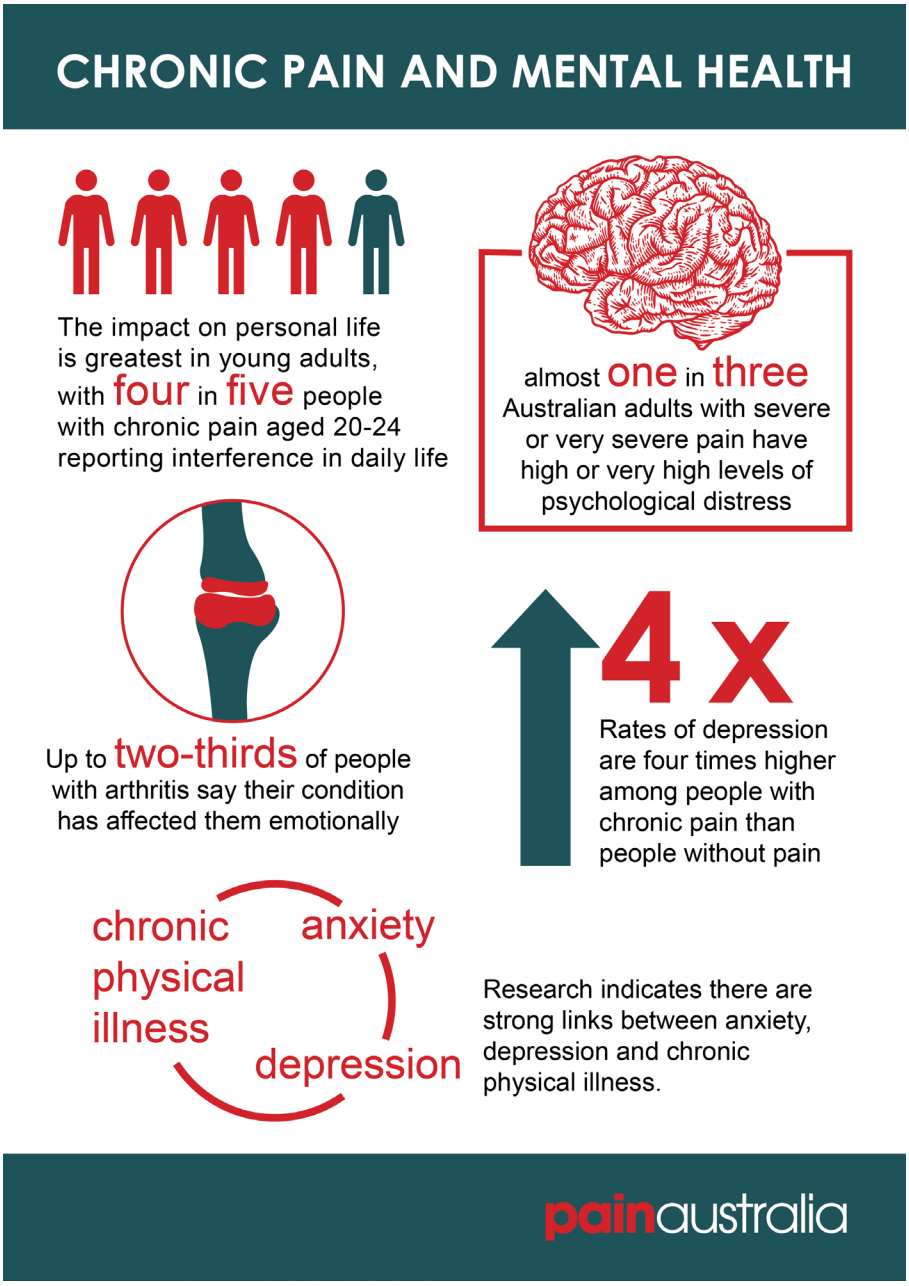
$2.7b **Out of their own pocket**

*In real 2018 dollars, and in the absence of changes to treatment or prevalence rates, and assuming that costs remain constant in real terms.

The impact of inaction

Despite the burgeoning cost and impact of pain, our current clinical pathways are failing consumers. An epidemic of pain in Australia has seen problematic increases in the level of harm and deaths due to opioid misuse. With over three million people prescribed 15.4 million opioid scripts in 2016–17 it is unsurprising that opioids now account for 62% of drug-induced deaths, with pharmaceutical opioids now more likely than heroin to be involved in opioid deaths and hospitalisations.[4] In 2016–17 there were 5,112 emergency department presentations and 9,636 hospitalisations due to opioid poisoning, with three deaths per day attributed to opioid harm, higher than the road toll.[5]

Currently the MBS does not support a best-practice treatment model, leading to unnecessary use of hospital-based services and more significantly, an over-reliance on medication including opioids, which is associated with significant harm. Nearly 70% of pain management consultations end with a GP prescribing pain medication. Another 13% will end in imaging, but less than 15% can hope to be referred to an allied health professional.[6]



This unfortunately means that for the 3.2 million people living with chronic pain, access to best practice care is problematic at best, and fatal at worst. Understandably the physical, mental and emotional toll of chronic pain impacts every facet of patients' lives. The lack of pain specialist care and GPs with limited options to deal with chronic pain means that millions of Australians are falling through the cracks of the country's health system.

MEDICINAL CANNABIS AND CHRONIC PAIN

Without access to or knowledge of best practice pain management, people in pain are seeking alternative treatment options. Chronic pain has not received the same priority in policy and public awareness as other chronic health conditions and remains misunderstood and neglected, despite its significant prevalence.

Despite the legalisation and decriminalisation of cannabis in some jurisdictions in Australia and overseas, there is still limited availability of well-designed clinical studies to support quality evidence for the use of medicinal cannabis for chronic pain and much public opinion on its use is influenced by anecdotes.[7]

Painaustralia supports current efforts to enable quicker access to medicinal cannabis where it has been correctly prescribed, and we have supported commitments made at the April meeting of the Council of Australian Governments (COAG) Health Council to streamline the application and approval process for unregistered medicinal cannabis and progress the development of a single national online application pathway.[8]

However, we are concerned that the accelerated push to embrace medicinal cannabis for chronic pain across jurisdictions, may have some unintended consequences. At worst, this could see millions of Australians living with chronic pain offered 'false hope' of a treatment option that has limited benefit and diverts them from seeking and accessing best practice pain management that offers them the best chance for a good quality of life and return to function.

The biopsychosocial framework that informs the assessment and management of people with chronic pain requires active engagement of patients in a multimodal management program, and this approach recognises the adverse effects that may be associated with polypharmacy in general and with cannabinoids in particular.

Evidence-base for use of medicinal cannabis for chronic pain

When it comes to chronic pain, there is a need to expand availability of safe and effective treatments as current treatments are not adequate. Studies to date have not systematically addressed this question in a large population of people taking opioids for chronic pain.

Despite the legalisation and decriminalisation of cannabis in some places here and overseas, there have only been a limited number of well-designed clinical studies on medicinal cannabis[9] and its role in treating chronic pain. There may be a niche role, pending on further research, in the management of complex chronic pain with distress.

Neuropathic or nerve pain is difficult to treat and can be debilitating. It can be caused by damage, injury or dysfunction of nerves due to trauma, surgery, disease or chemotherapy. Neuropathic pain can be the primary symptom of a stand-alone condition, such as multiple sclerosis or complex regional pain syndrome and can be associated with other conditions or forms of pain. We know more about the role of cannabis products in treating neuropathic pain than other forms of pain. There may be a niche role, pending on further research, in the management of complex chronic pain with distress especially in neuropathic pain.

There is little evidence about suitable doses of individual cannabis products, such as randomised controlled trials or systematic reviews, that enable definitive statements on effectiveness of medicinal cannabis. This lack of evidence makes it difficult for practitioners to prescribe, despite community expectations that these products will be made available to treat chronic pain.

Importantly, as the health risks associated with cannabis come under increasing scrutiny, pharmacovigilance during its use in growing numbers of people may uncover other problems.

The use of cannabis (particularly its principal psychoactive constituent, tetrahydrocannabinol or THC) is associated with health risks including lung disease (when smoked), cardiovascular disease, acute pancreatitis, and cannabinoid hyperemesis syndrome.[10] Cannabis users are also at increased risk for occupational injuries, and cannabis-associated "drugged driving"—sometimes fatal—is increasing. Finally, the myth that marijuana is nonaddictive has been dispelled by studies of forced abrupt cessation of use indicating potential rebound hyperalgesia and craving.[11]

Recent NICE (National Institute for Health and Care Excellence) Guidelines also do not recommend offering CBD to manage chronic pain in adults unless as part of a clinical trial. The Guidelines note that the evidence did not show a reduction in opioid use in people with chronic pain prescribed medicinal cannabis.[12]

As noted by the Australian Centre for Cannabinoid Clinical and Research Excellence (ACRE) Prescribing Guidance Prescribing Cannabis Medicines for Non-Cancer Pain (CNCP), currently there is insufficient information to make a recommendation about the role of medicinal cannabis in the treatment of pain associated with arthritis and fibromyalgia. The best evidence of medicinal cannabis currently refers to neuropathic pain states, although it is constrained by similar methodological issues of limited sample size.[13]

The Federal Department of Health coordinated a set of clinical guidance documents in late 2017 for prescribers treating a range of conditions, including chronic pain.[14] The reviews reveal in some ways the complexity of chronic pain, such as reporting of pain outcomes. In terms of prescribing, the guidance advises that the use of medications, including medicinal cannabis, is not the core component of therapy for chronic pain, favouring a comprehensive bio-social-physical assessment.

The Faculty Pain Medicine/Australian and New Zealand College of Anaesthetists (FPM/ANCZA) statement on the use of medicinal cannabis for management of patients with chronic pain concurs with this guidance.[15]

As noted in the Royal Australian College of General Practice (RACGP)'s Medicinal Use of Cannabis position statement,[16] there is a need for more public and medical education. This education should reflect the current state of knowledge and contextualise the use of medical cannabis as a last-resort medication for specific categories of illness that can only be prescribed in rare circumstances after stringent legislative criteria are satisfied.

Cannabis use and impact on mental health

It is also important to note that for those with psychotic disorders or at risk of developing them, medicinal cannabis may present higher risks. The comorbidity between mental and physical health problems is well documented, especially when illness becomes chronic. Nowhere do psychiatric and medical pathologies intertwine more prominently than in pain conditions.[17] Chronic pain deeply affects the capacity to work, mental health and wellbeing as well as relationships. Distressingly, it can also end in suicide.

As one of the peak bodies representing mental health expertise in Australia, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) has particular insight into the significant psychiatric morbidity associated with cannabis use. They note that several studies linked cannabis use to increased risk for chronic psychosis as well as worse outcomes for people who already have psychosis.[18]

Rates of mental health and suicide are higher amongst people living with pain. Major depression is the most common mental health condition associated with chronic pain, with among 30-40% of people with a diagnosed mental health condition also presenting for treatment for chronic pain.[19] High rates of generalised anxiety disorder, post-traumatic stress disorder and substance misuse are often present for people living with chronic pain.[20]

Almost a third of Australian adults with severe or very severe pain experience high levels of psychological distress; around three times the rate of those with mild pain and six times the rate of those with no pain. One in five Australian adults with severe or very severe pain suffer depression or other mood disorders.[21]

Suicidal behaviour is also two to three times higher in people with chronic pain than the general population.[22] While these figures are dramatic, chronic pain has not received the same priority in policy and public awareness as mental health (despite its significant prevalence among people with mental health conditions) and remains misunderstood and neglected.

It is paramount that treatments for pain management are based on rigorous evidence. The experience and expression of chronic pain varies between individuals, reflecting changing interactions between physical, psychological and environmental processes. The diagnosis of major depression in patients with chronic pain requires differentiation between the symptoms of pain and symptoms of physical illness, so specific clinical knowledge is helpful.[23]

Increasing understanding that chronic pain is a disease of the person, and that a traditional biomedical approach cannot adequately address all pain-related problems is critical, and this needs to be highlighted in the Senate's Inquiry.

Barriers to Practitioner Access

Several access issues remain, with poor uptakes by hospitals and multidisciplinary pain services, leaving a large unmet demand across the chronic pain population group. This has made the sector vulnerable and open to exploitation through “access clinics” that are usually supported by the pharmaceutical industry and therefore expose consumers to the increased risk of single modality of care, as well as high out of pocket costs.

Pain specialists have reported encountering many barriers in obtaining an authority to become an ‘Authorised Prescriber”. Even practitioners based at large hospitals who have applied with support of ethics committee have been denied access, as the requirements include listing every single product they wished to use, which is a difficult task as products are constantly changing. Thus, practitioners are forced to rely on single person applications each time, with a continuous audit/research program, and additional barrier to access.

Painaustralia supports improving current pathways through which practitioners can become ‘Authorised Prescribers’.

CONCLUSION

Despite the lack of a current evidence-base, medicinal cannabis may be considered an option of last resort for chronic pain management where a range of other therapies have been exhausted.

While Painaustralia supports current efforts to enable and expediate access to medicinal cannabis where it has been correctly prescribed, we remain concerned about the unintended consequences of inappropriate cannabis prescribing on a uniquely vulnerable cohort of consumers.

The development of a sound evidence base remains a critical enabler to ensure safe and effective use of medicinal cannabis in chronic pain and requires further research and investment as we still have much to learn about the role medicinal cannabis can play in addressing chronic pain conditions.

REFERENCES

1. Therapeutic Goods Administration 2017. Guidance for the use of medicinal cannabis in Australia Overview. Access online here https://www.tga.gov.au/sites/default/files/guidance-use-medicinal-cannabis-australia-overview.pdf
2. Op. Cit. Deloitte Access Economics (2019).
3. Deloitte Access Economics (2018), The cost of pain in Australia, p.iv.
4. Australian Institute of Health and Welfare 2018. Opioid harm in Australia and comparisons between Australia and Canada. Cat. no. HSE 210. Canberra: AIHW
5. Royal Australian College of General Practitioners (2018). Australian overdose deaths are increasing – and the demographics are changing. News GP. Access online here https://www1.racgp.org.au/newsgp/clinical/australian-drug-overdose-deaths-are-increasing-%E2%80%93-a
6. Deloitte Access Economics (2019), The cost of pain in Australia. Access online here https://www.painaustralia.org.au/static/uploads/files/the-cost-of-pain-in-australia-launch-20190404-wfrsaslpzsnh.pdf
7. Faculty of Pain Medicine Australian and New Zealand College of Anaesthetists 2015. Statement on "Medicinal Cannabis" with particular reference to its use in the management of patients with chronic non-cancer pain. Access online here.
8. Council of Australian Governments Health Council 2018. Communique. Access online here https://www.coaghealthcouncil.gov.au/Portals/0/CHC Communique 130418_corrected_1.pdf
9. Op. Cit TGA 2017.
10. Zhang MW, Ho RC. The Cannabis Dilemma: A Review of Its Associated Risks and Clinical Efficacy. J Addict. 2015; 2015():707596.
11. Carr,D. Schatman, M. Cannabis for Chronic Pain: Not Ready for Prime Time Am J Public Health. 2019 January; 109(1): 50–51. Published online 2019 January. doi: 10.2105/AJPH.2018.304593
12. NICE 2019. Cannabis-based medicinal products NICE guideline [NG144]Published date: November 2019. Access online here https://www.nice.org.uk/guidance/ng144/chapter/Recommendations#chronic-pain
13. Ware M. J Pain 2015; 16, p1221
14. Op. Cit TGA 2017
15. Op. cit. FPM 2015.
16. Royal Australian College of General Practitioners 2016. Medicinal use of cannabis products: Position Statement. Access online here https://www.racgp.org.au/FSDEDEV/media/documents/RACGP/Position statements/Medicinal-use-of-cannabis-products.pdf
17. Gatchel. R 2009. Comorbidity of chronic pain and mental health disorders: the biopsychosocial perspective. Am Psych 2009.
18. Royal Australian and New Zealand College of Psychiatrists 2017. Therapeutic Good Order No. 93 (standard for Medicinal cannabis) Access online here https://www.ranzcp.org/files/resources/submissions/0577o-president-to-tga-re-therapeutic-goods-orde.aspx
19. Alex Holmes, Nicholas Christelis and Carolyn Arnold 2013. Depression and chronic pain. Med J Aust 2013; 199 (6 Suppl): S17-S20. || doi: 10.5694/mja12.10589
20. Tang NK, Crane C. Suicidality in chronic pain: a review of the prevalence, risk factors and psychological links. Psychol Med. 2006 May;36(5):575-86. Epub 2006 Jan 18.
21. Blyth FM et al. Chronic pain in Australia: a prevalence study. Pain. 2001 Jan;89(2-3):127-34.
22. Tang NK, Crane C. Suicidality in chronic pain: a review of the prevalence, risk factors and psychological links. Psychol Med. 2006 May;36(5):575-86. Epub 2006 Jan 18.
23. Beyond Blue. Chronic physical illness, anxiety and depression. Access online http://resources.beyondblue.org.au/prism/file?token=BL/0124

painaustralia

Mailing address: PO Box 9406 DEAKIN ACT 2600
Phone: 02 6232 5588
Email: admin@painaustralia.org.au
Website: www.painaustralia.org.au