

painaustralia

**FUTURE FOCUSED
PRIMARY HEALTH CARE:**

**AUSTRALIA'S PRIMARY HEALTH
CARE 10 YEAR PLAN 2022-2032**

NOVEMBER 2021



Painaustralia is Australia's leading pain advocacy 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 on individuals and the community.

Painaustralia is pleased to have the opportunity to provide this submission to the consultation draft of *Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-32*.

Painaustralia has examined the draft plan through the lens of the needs of the people we represent: the 3.4 million Australians who are currently living with chronic pain, along with their families and carers. For these Australians, pain affects every facet of their lives. People living with pain have lower workforce participation and are more economically disadvantaged. They frequently face stigma, they are often socially isolated, and they have higher rates of depression, anxiety, and suicidal ideation. They may be dependent on medications to manage their everyday lives.

Like all chronic conditions, chronic pain is best managed in the community, and quality primary health care is critical in achieving good outcomes for people with chronic pain. Painaustralia therefore has a strong interest in the primary health care reform proposals.

Painaustralia notes the process that has been undertaken in the development of the draft PHC 10-year plan, the aims and objectives of the plan, the identified foundations for the proposed reforms, and the streams and action areas of the plan itself. Rather than providing detailed comment on each aspect of the draft plan, Painaustralia offers the following comments on key aspects of the proposed primary health care reforms.

1

Painaustralia supports the high level aims and objectives of the draft PHC 10-year plan.

The Quadruple Aim framework of improving people's experience of care, the health of populations, the cost-efficiency of the health care system, and the work life of health care providers, is unquestionably appropriate and laudable. Similarly, the objectives of the plan, which focus on access, closing the gap, keeping people well, continuity of care, integration, future focus, and safety and quality, are comprehensive and fit for purpose, and therefore strongly supported.

2

Painaustralia has significant reservations about the imminent introduction of Voluntary Patient Registration (VPR) as a key foundation for the proposed reforms.

Clearly patient registration with a practice has potential to improve continuity of care and can also act as an enabling platform for the introduction of much needed funding reform in primary care. However, we have significant concerns regarding the proposed implementation of VPR from July 2022, including the proposal that access to certain MBS-funded services (initially telehealth) will be contingent on patient registration from July 2023.

Our concerns relate to the lack of public communication on this issue to date, and what we believe is the lack of adequate consultation with health consumers. We believe there is little to no knowledge or understanding across the general population of Australia about the proposed system of VPR. For health consumers in general, and particularly for those with complex chronic conditions – including people who experience chronic pain – general practice is a critical part of their care, and they need to understand and have their say in the proposed reforms.

We acknowledge that there has been a high-level peak body consultation process, and it is clear a great deal of work has been going on behind the scenes including the overhaul of Services Australia systems to accommodate changes to enable the introduction of VPR. Yet to our knowledge there has been no broad communication process in relation to the proposed changes, with the result that very few Australians would be able to identify what VPR means, or to give their informed consent for registration with a practice. Very few consumers would be able to identify what the value proposition for VPR is, understand what their options are, or understand the implications and consequences of consenting or not consenting to registration. This is alarming, given the proximity of the proposed changes.

The information gap is particularly acute for our constituency, which has been dealing with and responding to significant changes in opiate prescribing rules, as well as all the challenges of the pandemic which have often affected people with chronic conditions even more than other Australians. This backdrop of immediate and urgent real-life concerns has precluded any possible focus in our sector on long term reform processes such as VPR, which have lacked perceived immediacy, and have not been communicated by Government in any meaningful way.

Painaustralia recommends that before proceeding further with preparations for the introduction of VPR, a broad communication process needs to be undertaken to enable public discussion of VPR; and that particular effort needs to be made to educate and inform consumers with chronic conditions, including chronic pain, who will potentially be most affected by the reforms.



3

Funding reforms need to be strongly focused on producing better outcomes for vulnerable groups and those with high health care needs.

The 10-year plan clearly foreshadows a shift in funding arrangements over time from the current fee-for-service model (supplemented by incentive payments), to a blended model in which a significant part of total payments to a practice will be linked to quality care and outcomes for the registered patient population. The plan flags that key objectives will be improved care for people with higher needs, including those with complex chronic disease, and a stronger embedding of multidisciplinary team-based care.

Painaustralia strongly supports efforts to properly fund multidisciplinary team-based primary care. Evidence confirms that people with chronic pain are best served by a multidisciplinary model of care that considers the physical, psychological, social and environmental factors that influence the experience of chronic pain. Multidisciplinary pain management interventions have been found to be superior to standard treatment of pharmaceutical and invasive care for chronic pain management¹.

In its current form, the MBS does not support this best-practice model, leading to unnecessary use of hospital-based services and more significantly, over-reliance on medication including opioids, which is associated with significant harm. Available data indicates that 68% of pain management consultations will 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 professional². This unfortunately means that for the 3.4 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, and nearly 1.45 million people in pain (or nearly 45% of patients) also live with depression and anxiety³.

Based on the report of an Expert Pain Management Clinical Committee established by the MBS Review Taskforce, Painaustralia has called for improved MBS support for high value care for chronic pain through multidisciplinary approaches including planning, monitoring and review through consultations, group pain management and telehealth. On the face of it, moving to a blended payments model which supports multidisciplinary team care and rewards quality care and outcomes has significant potential to improve the care provided to groups such as people with chronic pain, consistent with the contemporary clinical evidence. However, we would like to flag two provisos.

The first proviso is that the funding model must reward the provision of quality care for those with the most complex conditions and the highest health care needs. A large proportion of the population can be classified as having chronic conditions, yet the levels of need within this large group vary greatly. If these levels of need are not appropriately differentiated and stratified within the funding system, and/or if funding for those with the highest levels of need is inadequate, there will be incentives for practices to "cherry pick" and actively register patients for whom it is less costly to achieve improved outcomes. People with the highest needs for health care, particularly those from disadvantaged groups and those with complex chronic conditions, must be actively included in the VPR process, and appropriate levels of funding must be allocated to improving outcomes for these people.

A second proviso is that the needs of people with chronic pain must be specifically recognised in the funding reforms. Many disease-based definitions of complex chronic conditions focus on individual diseases, such as diabetes or coronary heart disease, and the impact of chronic pain can be overlooked despite the very high number of people who are affected by this condition, and the many mental and physical health comorbidities they often experience. It is vital that people with chronic pain are not side-lined in the implementation of the reforms.

4

People with chronic pain need equitable access to appropriate and targeted technology-driven advances in care.

Painaustralia notes the focus in the draft 10-year plan on using the opportunity of technology to drive improvements in access, quality, value, and integration of care. Examples of these advances in care include telehealth, virtual health care, data-driven quality improvements, digital integration, and precision medicine.



Clearly these advances have significant potential to improve care for people with complex chronic conditions, including those with chronic pain. Indeed, the recent widespread uptake of telehealth has greatly improved access to appropriate care for many people with chronic pain, particularly those who live in rural, regional and remote parts of Australia. While telehealth consultations must always be seen as complementary to, rather than a substitute for, face-to-face consultations, it is notable that with specialist pain services concentrated in metropolitan areas, telehealth has enabled much better access to care for people with chronic pain across all geographical areas. It is very important that these gains are not eroded through the exclusion of non-registered consumers from MBS-funded telehealth services.

We support consideration of the continuation of MBS telehealth services for allied health, mental health, and specialist care; and urge consideration of circumstances where it may be warranted to continue these services for general practice consultations with vulnerable and high needs groups.

Similarly, it is important that in the further development of digital health and technology-driven improvements in care, the specific needs of people experiencing chronic pain are consistently considered, and that every effort is made to be inclusive and to develop targeted initiatives to meet the needs of these consumers.

5

Painaustralia supports proposals to improve access to primary health care in rural areas.

There is a significant differential in access to health care, including primary care, between metropolitan areas and regional, rural, and remote areas. This impacts disproportionately on vulnerable and high needs groups, including people with chronic pain who live in these areas, who have limited or no access to appropriate local services and often limited or no ability to travel to metropolitan areas to access appropriate care.

People who live in regional and remote Australia are more likely to have chronic pain than those who live in major cities. For back pain, the most common form of pain, people who live outside major cities are 23 per cent more likely - and those aged 55 to 64 are 30 per cent more likely - to live with it compared with urban areas. Higher rates of pain may be associated with rural industries such as agriculture, mining, forestry and fishing which have higher rates of injury; and excess body weight - which is implicated in painful conditions such as osteoarthritis - is another factor⁴. Yet there are very few pain specialists and pain clinics in rural areas, making primary health care even more important.

In addition to supporting the continuation and extension of telehealth services, and other proposed initiatives, we particularly support the proposed trial of rural area community-controlled health organisations (RACCHOs), which we believe have great potential to attract the necessary workforce teams and to offer responsive, person-centred care which meets the needs of local communities.

6

The evaluation of the 10-year plan should include the impact of the reforms on vulnerable and high needs groups, including people experiencing chronic pain.

We are pleased to see the commitment to establishing a baseline evaluation framework and indicators for the evaluation of the plan, and to undertaking three-yearly and final evaluations. It will be critical that this framework and the indicators actively set out to measure the impact of the reforms on vulnerable and high needs groups, including people experiencing chronic pain; and that successful approaches are rapidly scaled up, while any negative impacts are identified and acted upon in a timely way.

Painaustralia thanks you once again for the opportunity to provide these comments, and we look forward to further opportunities to actively participate in the finalisation and implementation of the PHC 10-year plan.

1. *Deloitte Access Economics (2019), The cost of pain in Australia. Access online here.*
2. *Op. Cit. Deloitte Access Economics (2019).*
3. *Op. Cit. Deloitte Access Economics (2019).*
4. <https://www.painaustralia.org.au/about-pain/who-it-affects-pages-2021/rural-remote-2021>



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