SUBMISSION TO THE STANDING COMMITTEE ON HEALTH PARLIAMENTARY INQUIRY

CHRONIC DISEASE PREVENTION & MANAGEMENT IN PRIMARY HEALTHCARE

JULY 2015

painaustralia™
working to prevent and manage pain

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INTRODUCTION

Thank you for the opportunity for Painaustralia to make a submission to this Inquiry. Our submission draws upon the recommendations of the National Pain Strategy (2010)[1] to improve the prevention and treatment of chronic pain — one of the most neglected health problems facing Australians of all ages and walks of life today and into the future.

Our vision is of a society where chronic pain is understood and effectively managed, where possible in primary care, using evidence-based, best practice strategies, with clear and accessible referral pathways though to adequately resourced tertiary care clinics, for more complex cases (see Figure 1 pg 29).

Our submission addresses each of the **Terms of Reference** of this Inquiry and is consistent with Federal Government policies which aim to:

- **Create a more efficient primary healthcare system** that ensures improved health outcomes, more effective use and sustainability of the Medicare Benefits Schedule and the Pharmaceutical Benefits Schedule (Primary Care Health reform[2]) and better treatment outcomes for veterans.

- **Improve productivity** and keep older Australians in the workforce (Federal Budget – Economic Action Plan).[3]

- **Ensure effective management of the social security budget** including the Disability Support Pension.

"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
Director Painaustralia, Chair National Pain Strategy
Medical Journal of Australia October 2014

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[4], 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.[5 6]

Studies in other developed nations show a similar or higher prevalence[7]. This points to an escalating and increasingly costly health problem, exacerbated by Australia's ageing population.

The 2010 Global Burden of Disease (GBD) Study 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, or DALYs) and represent a major cause of lost productivity in Australia.[8] The Australian Institute of Health & Welfare reported that low back pain alone accounted for 420,734 DALYs in 2010, second only to coronary heart disease.[9]

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.[10]

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.[11] Indeed, the World Medical Association recognises chronic pain as a chronic disease.[12] 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 healthcare costs and $11.7 billion in lost productivity.[13] This equates to 36 million lost workdays per annum.[14]

The report estimated that half of these costs could be saved with the provision of timely, best practice pain management services, with the majority of cases managed in the community or primary care.

A Carers Australia survey revealed associated costs to people caring for people in pain. Over half reported some level of depression, with one third found to be severely or extremely depressed.[15]

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)[16] and the major cause of forced workplace retirements leading to lost productivity, reduced taxation revenue and the need for welfare payments.[17]

For families and carers, there is also an estimated loss of earnings of over $6.5 billion a year.[18]

Arthritis and back problems, both associated with chronic pain are the most common reasons people of working age (between 45 and 64) drop out of the workforce, accounting for 40% of forced retirements — around 280,000 people in 2003.[19] 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.[20] Data from the USA reflect an even larger problem.[21]

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 unable to work due to their condition forego $3.8 billion in income, and cost the government $290 million in social security payments, and almost $400 million in lost tax revenue.[22]

"Mental health is now a public health priority. But recognition of chronic physical pain is still at least 20 years behind...If we're going to come up with a new focus to beat chronic pain and improve productivity at the same time, we have to get a new nexus between health, economics and welfare - disciplines that haven't always talked to each other about finding the most effective way."

Professor Deborah Schofield
Director Painaustralia
Professor and Chair of Health Economics, Faculty of Pharmacy, University of Sydney

BEST PRACTICE CHRONIC PAIN MANAGEMENT - BARRIERS TO ACCESS IN PRIMARY CARE

Like all chronic conditions, chronic pain is best managed in the community with a multidimensional approach which involves education and supported prevention and self-management strategies, with only more complex cases being referred to specialist pain clinics in tertiary hospitals.

Despite this obvious approach, best practice evidence-based pain management services and expertise are not generally available in primary care. Moreover, in the limited cases where such services are available, they are out of reach for most people as they are not adequately supported by Medicare or private health insurance rebates.

The major barriers to the provision of effective pain management in primary care are:

- Lack of uptake of available education and training for the primary healthcare workforce (GPs and allied health) to develop the capacity, knowledge and expertise to provide best-practice multidisciplinary pain management.

Note, we define **education** as knowledge development or learning through information sharing, reading, courses, lectures, online programs etc, and t**raining** as practical skills development through experience and supervised practice (with health professional team interaction and patient involvement)

- Lack of appropriate funding models – both MBS and private health – for individual or group care plans for people with chronic pain.
- Lack of compensation and incentives for GPs to properly assess people with chronic pain and to plan and coordinate multidisciplinary treatment programs.
- Lack of funding for consumer education and support programs which promote self management strategies ahead of passive treatments.

On the positive side, there are some patient cohorts who do have access to more appropriately funded models for prevention and management of chronic pain through:

- **The Coordinated Veterans' Care Program (CVC)** which provides integrated care and incentives for GPs to develop and coordinate chronic disease care plans for complex chronic conditions including chronic pain which is a major issue for veterans of all ages.[23]

- **Some Workcover programs** – available through accredited Workcover providers:

  - Comprehensive early assessment and intervention after injury to prevent progression to chronic pain; (see Workplace Trial evaluation TABLE 1.)
  - Individual chronic pain care plans; and
  - Group multidisciplinary pain programs.

Similar models of care are needed for people in the general community who suffer from chronic pain including older Australians with a potentially complex range of co-morbidities, as recommended in the National Pain Strategy.[24]

OTHER MAJOR ISSUES

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:[25]

- 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, 25% 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)[26] 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.[27]

Poor management of pain in aged care

Department of Health and Ageing data from 2012 show that there are around 169,000 people in residential aged care, 80 percent of whom (135,000 people) live with chronic pain. However evidence suggests that pain is often under-treated or poorly treated in the elderly, especially among those living in residential aged care.[28 29]

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.[30 31]

Painaustralia recommends improved access to education and training about chronic pain and its management for aged care workers and primary healthcare professionals as a first 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.[32]

Urgent need to address inappropriate prescribing of opioids

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[33] in developed countries.[34] It is likely to be the result of:

- Lack of education about alternative ways to treat and manage chronic pain.[35]
- Lack of 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.[36]

GPs who have had training in psychological therapies though the Pain Management Research Institute, University of Sydney training programs have reported they were subsequently 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.[37]

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.[38] [39]

"There were 806 oxycodone-related deaths, with a significant increase in the 11-year period, from 21 deaths in 2001, up almost sevenfold in 2011 (139 deaths) ... Most individuals were male (59.1 %), aged 35–44 years (26.7 %), who died unintentionally (56.4 %), with mental illness (52.1 %) and/or a history of acute or chronic pain (46.2 %).

312 cases (39 %) described a legitimate prescription for oxycodone, of which most involved non-cancer related chronic pain. About three quarters of the indications were deemed appropriate."

Pilgrim JL et al. 2015 Forensic Science, Medicine, and Pathology 11(1): 3-12

RECOMMENDATIONS TO ADDRESS TERMS OF REFERENCE

1. Examples of best practice in chronic disease prevention and management, both in Australia and internationally

a. Osteoarthritis Management – Healthy Weight for Life Program

The Osteoarthritis Healthy Weight For Life™ program is an example of an innovative Australian best practice non-surgical knee and hip osteoarthritis disease management program that has been proven to assist overweight patients with advanced knee or hip osteoarthritis to systematically implement a comprehensive osteoarthritis management program and achieve significant and measureable clinical outcomes.

The innovative health service delivery model developed by Prima Health Solutions is underpinned by a proactive drive to engage and empower individuals to improve their disease specific health literacy (knowledge, motivation and competencies) in order to maximise clinical outcomes.

This is achieved by utilising a plan-do-study-act methodology for each patient where the desired, clinically meaningful and personally relevant outcomes are proactively driven (rather than passively relying on a static plan to deliver meaningful outcomes).

Some key features of the model of care are:

- Proven to replicate significant clinical outcomes achieved in clinical research protocols conducted in specialist tertiary settings.
- Proven to produce significant clinical outcomes irrespective of where a patient lives within Australia or what health services they have access to. Rural, remote and metropolitan based patients all achieve the same clinical outcomes.
- Systematically and remotely implemented from a single hub of excellence allowing a small highly skilled team of allied health facilitators and program navigation experts to efficiently manage large groups of patients to achieve predictable and clinically significant outcomes.
- Provided directly and remotely to patients following a simple medical referral or approval. This allows the primary health care provider to make a single referral which then triggers an intensive, multi-dimensional, quality assured, behaviour modification intervention that has the systems, processes, resources, technology and people required to engage, monitor and manage each patient individually. At the completion of the program a detailed outcome report is sent to the referring GP.
- Bespoke technology enables 'real time' analysis of individual outcomes as well as extensive de-identified cohort reporting

This innovative system-based disease management model could be readily adapted and developed to address chronic pain, particularly chronic back pain.[40]

b. The US patient-centred medical home model

Painaustralia supports the Royal Australian College of General Practitioners' (RACGP) proposals for adoption of a Patient-Centred Medical Home Model similar to the US model as proposed in their consultation paper.[41 42] The model provides scope to deliver patient-centred multidisciplinary care that is essential in the management of chronic conditions, including chronic pain.

Evidence from the US indicates the model promotes improved coordination of patient care and reduced reliance on hospital based services including emergency visits.[43]

The US model also offers the incentive of shared savings rewarding practices which meet agreed targets, improved patient outcomes/satisfaction and reduced service utilisation.

We understand and support the fact that the adoption of this model will require comprehensive system and funding changes.[44] We recommend two parallel funding systems or streams from which medical practitioners can choose the most appropriate option: episodic care or chronic care.

c. The Coordinated Veterans' Care (CVC) program

This program has received strong support from the Royal Australian College of General Practitioners (RACGP). The CVC program offers financial incentives to practitioners based on patient outcomes. The Department of Veterans' Affairs (DVA) has incorporated access to improved methods of treating chronic pain into the CVC program.[45]

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's services also embrace community support for veterans with pain through the MATES program which provides community support and promotes self-care.[46] 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 healthcare 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
Former Principal Medical Adviser, Department of Veterans' Affairs

d. Multidisciplinary pain programs

There are a number of best practice models for managing chronic pain offered by public hospitals in Australia and in the community. These include:

- ADAPT Pain Management Research Institute— Royal North Shore Hospital
- STEPS (Self Training Educative Pain Sessions) Fremantle Hospital and Perth North Medicare Local/Panaroma Health
- Hunter Integrated Pain Service - Newcastle New South Wales
- Austin Health - Victoria StepIn, StepUp, StepForward
- Central Coast New South Wales Pilot Program

Details of these programs are covered later in this submission Section 7 & 8 pages 22-25.

e. Brief pain management program

Low back pain is one of the most common symptoms prompting adults to seek healthcare. The costs of low back pain, both in terms of healthcare and lost productivity, are enormous. Despite a great deal of effort in the past decade, most of the treatments for low back pain have been ineffective or at best marginally effective.

This reference is for a randomised clinical trial in physiotherapy practice[47 48] which compares results of physical treatments for back pain with a **brief pain-management program** for back pain in primary care.

2. Opportunities for the Medicare payment system to reward and encourage best practice and quality improvement in chronic disease prevention and management

a. Medicare item number for a chronic pain care plan – different number from other chronic disease plans

The experience of chronic pain is complex, and best-practice chronic pain management requires a multidisciplinary approach which takes into account the physical, psychological and social or environmental factors associated with the pain. A primary care team would typically include a GP, nurse, physiotherapist and clinical psychologist, all with special education and training in pain management. An accreditation system is also proposed (see below) which would link to Practice Incentive Payments.

The experience of pain is often linked to psychological disorders such as depression and anxiety, and patients benefit significantly when such factors are addressed as part of a comprehensive assessment and treatment program.[49]

Studies undertaken in the workplace setting demonstrate that early intervention including psychological assessment and support can prevent the transition of acute or sub-acute pain to chronic pain.[50 51]

Painaustralia recommends a Medicare Item Number for Chronic Pain Care Plan which combines the Chronic Disease Management Plan (5 allied health consultations) and the Mental Healthcare Plan (6 plus 4 sessions with a clinical psychologist); with the Item number being available only to accredited practitioners including GPs and allied health professionals.

The item number would allow for an extended assessment/consultation with an accredited GP and the development and coordination of a care plan with up to 15 visits to appropriately accredited allied health professionals (see point b. below).

b. Accreditation for GPs and allied health professionals

Pain Management Accreditation would be awarded to GPs, pharmacists, nurses and allied health professionals who complete a specified level of education and training, and undertake ongoing CPD requirements. Suitable education programs would include:

- RACGP GP Learning Pain Management Program.[52]
- Faculty of Pain Medicine Better Pain Management program for GPs, nurses, pharmacists, allied health.[53]
- Pain Management Research Institute, University of Sydney Pain Management Education Programs and Webinar Training.[54]
- Basic pharmacotherapy training would also be of value to facilitate more effective assessment and management.

Painaustralia recommends that access to the Medicare Item number would be linked to accreditation based on education and training and would also require:

- Mandated use of agreed assessment and management tools; (as developed by NSW ACI Pain network).[55]
- Case conferencing and/or a minimum level of communication between GP and allied health professionals, which specifies "clinically important content of communication, including proven documentation between team members".
- Use of **My Health Records** electronic recording system as an integral component of the care plan.
- Optimum/maximum waiting times from referral to first appointment (as for ATAPS) may also be linked to funding.

c. MBS item number for specialist GPs

A growing number of GPs are choosing to specialise in Pain Medicine, with dual degrees as Fellows of the Faculty of Pain Medicine (FFPMANZCA) and FRACGP.

Painaustralia recommends that an MBS Item number be available for care by GP specialists, enabling them to direct team-based arrangements and consult with other GPs to

help manage complex patients.

These highly skilled health professionals are trained to specifically manage patients with chronic pain, coordinate multidisciplinary services and provide pain management education to individuals and groups. Specific funding for this relatively small number of specialists with a targeted Medicare Item number would create a sustainable funding model for community based pain services, improve patient accessibility and reduce burden on hospital based services. These professionals can also provide Telehealth support to GPs and patients in rural and remote communities.

d. MBS funding for participation in group pain programs

Group pain management programs have various formats and may be high, medium or low intensity programs.[56]

Such programs run in primary care pain clinics have shown positive patient outcomes, (e.g. Western Australia and Central Coast examples provided below. There is also evidence of the value of clinics delivered by nurse practitioners.[57]

Some Medicare Locals developed pre-clinic programs where patients on the waiting list for tertiary clinics (often for a year or more) were offered a low intensity program as an interim measure, funded from core or flexible funds.[58]

However there is limited or no funding available for these programs from Medicare or private health funds.

Painaustralia recommends a chronic pain group program similar to that funded by Medicare for group Mental Health programs.[59] This would have significant value in supporting self-management with people living with chronic pain.

e. Telehealth to support access to multidisciplinary pain management teams in primary care

Several tertiary pain clinics in most states are currently providing support to GP led multidisciplinary teams in primary care settings in regional and rural Australia.[60] However funding models to support this are inadequate. While funding is available for some team members, there is no funding for example, for physiotherapy services. It is important to acknowledge that most physiotherapy in pain management does not involve "hands on" therapy but rather promotes improved function and self-management strategies through movement and specially tailored exercise. This kind of therapy can be delivered very well via telehealth.

It is important that the chronic pain care plan allows this form of delivery in order to provide services in rural, regional and remote communities where the incidence of chronic pain is often higher than in metropolitan areas.[61]

It is understood that the Royal Flying Doctor Service is often called on to manage chronic pain conditions, so access to support from experts in tertiary clinics via telehealth would be valuable in this situation.[62]

Painaustralia recommends Telehealth funding for GP led allied health primary care teams including physiotherapists and clinical psychologists.

f. Paediatric pain services

While the majority of people living with chronic pain are middle aged or older, it also affects significant numbers of children and young people. Back pain is one of the most common long-term health conditions reported by teenagers and young adults.[63] Unfortunately teen-agers over the age of 16 are not eligible to be treated by public paediatric services and are not appropriate clients for adult pain clinics. Such patients require treatment in the community by a paediatric pain specialist.

Paediatric Pain clinics in NSW are providing valuable support via Telehealth to GP-led teams, but only in regional areas, supported by the NSW Pain Plan. Paediatric pain management is a key area of need.

Painaustralia recommends enhanced funding for paediatric pain services in all jurisdictions.[64]

g. Medicare item number for Pain Educator (PE)

There is evidence that education about chronic pain and self -management skills can lead to positive improvements in a person's pain experience and function.

Such education can be provided by a Pain Educator. This is a healthcare professional who provides education about pain assessment, evaluation, and management within a clinical practice or via formal presentations and direct contact with other healthcare professionals and/or patients. The USA has a well-functioning society of certified pain educators.

Pain educators may practice in a wide range of healthcare settings, e.g. medical and dental practices, community pharmacies, rehabilitation services, hospice and palliative-care facilities, residential aged care facilities, physical and occupational therapy practices with a focus on transferring knowledge to and teaching others about pain.[65]

Australia already has accredited Diabetes Educators who play a key and valued role in the ongoing support of people living with and self-managing their diabetes.[66]

Painaustralia recommends the establishment of a similar certification, accreditation and funding process to that of Diabetes Educators for Pain Educators.

This is potentially an expanded role for a nurse or allied health professional requiring a specified level of education and accreditation which provides access to an MBS Item Number.

3. Opportunities for the Primary Health Networks (PHNs) to coordinate and support chronic disease prevention and management in primary health care

a. Facilitation of effective pain management education and training for GP-led teams including special training for those working with CALD and Indigenous Communities

Some progress was made through the Medicare Locals to facilitate access to education and training for primary care teams to build capacity to deliver pain management services in particular in rural and regional areas.[67]

Painaustralia recommends PHNs be supported to continue this work, allocating funding for web-based education and 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.[68] This may include:

Online pain management education programs
Developed by the Faculty of Pain Medicine (ANZCA). These programs are now available – at no cost or low cost – to GPs through the RACGP and to all primary healthcare professionals through the Faculty of Pain Medicine, ANZCA.

Practical skills-based training
This may be provided locally through links with tertiary services. However access to face to face training is 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 developed by the Pain Management Research Institute, University of Sydney is now available in a novel online format.[69] This has been trialled 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.

In 2013 this program received funding from the federal Department of Health, which enabled training to be delivered through Medicare Locals for around 80 healthcare professionals around the country. However, there are over 100 on the waiting list, pending access to additional funding.[70]

Painaustralia strongly recommends the development of workforce capacity is a priority for the new PHNs, with strategic direction from the federal Department of Health. This will help address major gaps in services. Special training and resources will be required for teams working with CALD and indigenous communities. The NSW ACI Pain Network is currently developing strategies for this.[71]

b. Professional pain management networks

Facilitation and support is needed for community-based pain professional networks. A good example of this is the Mental Health Professionals Network (MHPN) which embrace GPs, pharmacists, nurses, allied health, residential aged care, working with pain patients within the PHN community.[72]

Such networks can foster continuing education and develop/improve standards of practice, clinical processes and communication systems to help support/maintain accreditation (CPD requirement).

As an example, the MHPN provides practitioners the opportunity to participate in interdisciplinary professional development programs and team-based practice. To date MHPN voluntarily dedicated more than 57,000 hours to further interdisciplinary collaboration through MHPN and webinars in 2013/14, with 385 networks established and supported and 41% of networks in rural/remote regions.[73]

c. Development of Integrated Pain Health Pathways (or similar, e.g. Map of Medicine)

Development of integrated linkages between primary, secondary and tertiary facilities to ensure effective triage for patients allowing appropriate referral, use, and timely access to pain management services through Integrated Pain Health Pathways.[74]

Painaustralia recommends the work of developing Integrated Pain Health Pathways, which began under a number of Medicare Locals, should continue under the new PHNs. However, there is considerable variability in this activity although epidemiological studies show that chronic disabling pain is represented across all regions.[75]

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.

d. Community awareness prevention and management

There is an opportunity for PHNs (as well as state and federal governments) to promote community awareness of chronic pain through programs similar to those used in mental health, such as RUOK, which involved employers, sporting and other community groups in awareness and education about management of mental health and prevention of suicide.[76]

Another excellent community awareness program was Mental As[77] which created widespread awareness of mental health issues through the ABC and raised over $1.4M to support Mental Health Week.

The use of mass media to deliver community health messages is a well-established public health strategy. The Back Pain: Don't Take It Lying Down campaign by the Victorian WorkCover Authority, is a prototype of a successful public health strategy designed to enhance people's self-management abilities.[78]

Painaustralia recommends that Primary Heath Networks build on the current opportunity of Chronic Pain Australia's Annual National Pain Week initiatives to promote better pain management and awareness and reduce the stigma for many people living with chronic pain.

e. Community and peer support programs

i. Community-based support programs and Help Line

The Australian Pain Management Association (APMA) has developed a model for community support groups that fosters peer support and consumer education around self-management of chronic pain. It also runs a community help line. All services are currently run by volunteers. There is potential to expand these programs nationally if funding is available.[79]

It has been demonstrated that local support groups add a measurable benefit to consumer outcomes for a significant number of chronic conditions. Alzheimer's Australia[80]; Diabetes Australia; Cancer Australia; Arthritis Australia are examples.

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 those 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.

ii. Online peer support programs

Online support forums are a good source of information and social and psychological support[81] for those living with chronic pain where desperation brought about by isolation and stigma has caused them to look to the internet for information. Growing evidence supports the potential positive impact of online peer support, including reduced sense of isolation, increased self-efficacy, reduced anxiety[82] and validation of members' thoughts, feelings and experiences.[83] Chronic Pain Australia (CPA) has a forum with over 1,600 registered users and a daily readership of between 400 and 1,000 at any time of day or night throughout the year. However, after media coverage of National Pain Week, there is a substantial spike in the readership, up to almost 5,000 in 2014.

Some of the most desperate of these readers post their stories of pain, with their suffering highlighted by stigma, isolation and lack of validation. They are essentially seen as malingerers and drug users by family, friends and often by health professionals.

Many close to suicide allude to this in their posts with statements like, "I am desperate for help because I can't take this any longer and am about to end it all!" This is a commonly held feeling for many marginalised by chronic pain.

Many of these people will then post positive responses to the replies they get from reaching out for help. They are of course talking to peers who validate their pain condition and treat them with respect.

Suicide is then a reduced risk for these people, because they have found hope of managing chronic pain: a direct result of the contact with others who live the best life they can in spite of their ongoing pain.

Painaustralia recommends priority funding for community and peer support programs including a helpline.

f. Engaging pharmacists in community support and education

Community pharmacists working in collaboration with local GP-led networks can provide ready access to general health and pain management education and advice that goes beyond medication which alone is generally not helpful for chronic pain. Community pharmacists are also able to refer patients as appropriate, to a helpful GP or other members of a local pain management network. The Pharmaceutical Society of Australia is interested in embracing the concept of the **Pain Educator** and so enhancing the value of community pharmacy as centres of excellence in providing healthcare support and advice.

The Pharmacy Guild has provided education and resources for pharmacists to be more pro-active in providing advice for people with pain. Such advice includes consumer education about self-management strategies and Quality Use of Medicines (including opioids and other frequently over-used or misused medications).[84]

Painaustralia supports the Guild's proposals for pharmacists (with appropriate education and accreditation) to be able to charge a fee for providing advice on pain management where the patients deems this to be helpful. Access to such advice can fill a gap between government provided services and high-cost private care options.[85]

The Pharmacy Guild's pain initiative aligns with current NPS MedicineWise campaigns for GPs and consumers which emphasise the need for multidisciplinary strategies and minimal reliance on medication, especially potentially harmful opioids for chronic pain.[86] Painaustralia contributed to these campaigns.[87]

Painaustralia recommends further development of NPS MedicineWise programs for community-wide education about pain management. We also support The Pharmacy Guild's proposal for appropriately accredited pharmacists to charge for advice.

4. The role of private health insurers in chronic disease prevention and management

a. Rebates for chronic pain prevention and management programs

Most current private health insurance arrangements largely favour hospital based treatments (e.g. surgical interventions) ahead of prevention and self-management strategies for chronic pain, despite evidence that some surgical procedures are ineffective (e.g. knee arthroscopy).[88]

On the other hand there is good evidence to support the role of Cognitive Behavioural Therapy, physiotherapy, meditation, yoga and other non-invasive therapies, which do not attract adequate rebates.[89] [90] [91] [92] [93]

Painaustralia recommends private health funds place a much greater emphasis on reimbursements for prevention, early risk identification and non-pharmacological strategies for managing pain including refunds for participation in group pain programs.

Some of the larger private health insurance funds run chronic disease management programs for selected members. There is a good case to be made to include people living with chronic pain in this cohort.

b. Osteoarthritis Management – Healthy Weight for Life Program

This specialised knee and hip osteoarthritis management program, developed by Prima Health Solutions is currently funded by number of private health insurers for eligible members.

The program which is demonstrating very positive outcomes, could be readily adapted as a chronic disease management model suitable for chronic pain, particularly back pain.

The OA program is designed to improve day to day living and quality of life by reducing joint pain and stiffness and improving the function of affected joints. It can also reduce the need for surgery; or improve fitness for surgery if required.

The program provides a comprehensive resource kit along with active monitoring and support from a central service hub Outcome data is collected, with aggregated data from over 7000 participants showing significantly improved pain and mental health scores and improved quality of life. The program is available at no cost to eligible members of participating funds.

Painaustralia strongly recommends the Prima Osteoarthritis system-based disease management model is adapted and developed to specifically address chronic pain, especially back pain. The model offers particular value for people living in rural, regional and remote Australia, where this level of expertise and direct support is not available.[94]

5. The role of State and Territory Governments in chronic disease prevention and management

a. State-Wide pain plans

The **NSW Agency for Clinical Innovation (ACI)** has shown outstanding leadership in forming the ACI Pain Network to develop a comprehensive State-wide Pain Plan with the purpose of ensuring everyone in the state has access to pain services as required in a timely manner. Significant progress has been made to address long waiting times at public hospital clinics and lack of services in rural and regional areas.

In order to overcome the demands on public hospitals, the ACI Network has facilitated education, training and support for health professionals working in primary care to ensure that only the more complex patients are referred to the tertiary pain centres. This strategic, collaborative approach is producing significantly improved patient satisfaction and reduced waiting times for services.

However while confirming significant benefits to patients overall, the formative evaluation report revealed a lack of uptake of the available education and training by GPs and limited progress in primary care, despite available strategies and support.[95] There is anecdotal evidence from GPs that the lack of suitable funding models and incentives is a key contributor to this problem.

The ACI Chronic Pain Management site has a wide range of resources for consumers and clinicians and provides a location for the multilingual 'Brainman' pain education videos. Since 2013 the site has reported 214,097 hits with more than 33,761 visitors.

Painaustralia recommends the NSW ACI State-Wide Pain Plan could be replicated in every Australian state and territory building on existing resources such as the ACI pain management website.[96]

More recently **South Australian Health** has developed a **Chronic Pain Service Plan**, which will be integrated into the SA Transforming Health program. This draws substantially on the NSW Plan and is tailored to address massive service gaps especially in rural and regional SA (for release shortly).

A collaboration in Western Australia developed the **painHEALTH** website which provides information and self-assessment for clients with musculoskeletal pain. Since launch in 2013 the website has reported 4,027,992 hits, more than 258,182 visitors, averaging 309 visitors p/ day and visited from 142 countries.

NSW Chronic Disease Management Program

NSW Health has been operating a chronic disease management program since 2009. It targets people at high risk of hospitalisation with the following five conditions: diabetes, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease (COPD) and hypertension.

The operational model has six elements: targeted enrolment, comprehensive assessment, shared care planning, care coordination, self-management support and monitoring and review. While the evaluation report is equivocal about the program's success, it is nonetheless very clear about the general principles of extending acute care into primary care through effective risk stratification. The evaluation report also emphasises the value of engagement between acute and primary care to provide a comprehensive focus on chronic disease prevention and management.[97] These principles apply equally to chronic pain.

b. State and Territory support for nationally consistent data (ePPOC)

NSW Health has provided seed funding to establish the Electronic Persistent Pain Outcomes Collaboration (ePPOC)[98] and this is now collecting data from 45 public hospitals in NSW, Queensland, Victoria, Western Australia and New Zealand, funded by state governments and NZ Health.

The ePPOC will ensure continuous evaluation and reporting on the effectiveness of pain programs as the basis for continuous improvement and identification of best practice.

The ePPOC also has the capacity to collect data from primary care pain programs, however the cost of this – $35,000 per clinic – is preventing private clinics from participating.

The lack of data from primary care clinics is a major barrier to promoting best practice in pain management in primary care and supporting the case for change.

Painaustralia recommends a more strategic approach to funding the ePPOC which has federal government and private sector funder support, including WorkCover authorities and private health insurance funds. This would enable all public and private pain clinics to participate and provide valuable data to all federal and state governments as well as Workcover and private health funders.

6. Innovative models which incentivise access, quality and efficiency in chronic disease prevention and management

See Osteoarthritis Health Weight for Life Program (1. a above)
See Patient-Centred Medical Home (1. b above)
See Department of Veterans' Affairs CVC Program (1. c above)

7. Best practice of Multidisciplinary teams chronic disease management in primary healthcare and Hospitals

The following summarises the Health Benefits and Costs Savings resulting from multidisciplinary pain programs in the workplace and in a hospital setting:

In the workplace

Significant health benefits and cost savings were clearly demonstrated in a trial 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.[99]

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. The results will be available later in 2015.

ADAPT: Delivered in a hospital setting (could also be offered in primary care)

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:[100]

1. Rehabilitation

- 92% of patients completed the 3-week hospital phase (i.e. 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 did not preclude 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 does not 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%
  - o3-4 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.

Opioid usage

Prior to ADAPT, just on 40% were taking 1 or more opioids for their pain (60% were on none). The opioid takers were worse on almost all measures than those not taking opioids (on average pain, depression, disability, unhelpful beliefs), but by the end of the program only 10% were still taking an opioid and 90% of the total group (vs 60% at baseline) were on none.

These figures remained the same throughout the following year. Those who were taking opioids prior to the program but ceased during the program improved significantly and actually caught up on all measures (pain, disability, depression) with the ones who were not on opioids initially (and they also improved significantly during the program). So, by the end of the program, and at one yr follow-up there was no difference on these measures between

the two groups. Those who remained on opioids did not do as well but their numbers are too small to analyse.

ADAPT offers an effective pain management alternative to long-term use of opioids in a chronic pain population.[101]

8. Models of chronic disease prevention and management in primary health care which improve outcomes for high end frequent users of medical and health services

Community Pain Management Programs

a. STEPS

In Western Australia, Perth North Medicare Local delivered 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.[102]

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 patients satisfaction.[103]

- Clinic 1: waiting times reduced from 105.6 weeks to 16.1 weeks
- Clinic 2: waiting 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 run by Perth North Medicare Local reported 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.

b. Hunter Integrated Pain Service

Hunter Integrated Pain Service (Newcastle, NSW) — patients with chronic non-cancer pain are seen in groups in tertiary care for an orientation session and then followed up with a group based assessment where the patient co-develops their own pain management recovery plan. This has slashed wait times. This team is waiting to publish the results of RCT in 'Pain Medicine'.

c. Austin Health

Austin Health offers `StepIn', a 10 hour education model taught by psychologist, physiotherapist and pain doctor. This is the entry point to their service, except for cancer pain, people with insufficient English language skills and acute Complex Regional Pain Syndrome (CRPS) or orofacial pain. Clients can proceed to StepUp, conducted 6 hours per day. one day per week, over 8 to 10 weeks, and then to StepForward, which can include any of a selection of services aimed at transitioning the client back into their community.

d. Central Coast Pilot

The key outcomes of a recent pilot of a community-based multidisciplinary pain program showed increased functionality of participants and decrease of pain related GP consultations. The Central Coast Medicare Local supported by the ACI Pain Network operated a series of five low intensity chronic pain management programs.[104] [105] The programs ran for 18 hours over 6 weeks and participants were reviewed at four weeks and twelve weeks post program:

Program cost was $600 per participant ($6,000 for group of 10).

All participants demonstrated an improvement in 2 or more measures of the ePPOC tool at the twelve week review. Although the average scores, for the participants as a whole, do not demonstrate clinically significant changes, 75% of participants showed a clinically significant gain in one or more measure. The majority of participants identified improvement in functional abilities and progressed 60% or more towards their individually identified SMART goals.

Participants rated satisfaction with the program highly and comments were positive indicators of the program's empowerment of participants to manage pain and regain a functional lifestyle.

Referring General Practitioner feedback indicates noticeable changes in participant's coping strategies and a decrease in pain related consultations. Fifty percent of referrers, who provided feedback, would continue to refer to a similar program based on the results noted. The referrers were approached for feedback six weeks following their participant's final review.

These examples support the case of funding of group pain programs as recommended in 2.d

"Today, I manage my pain through regular meditation, plenty of stretches, and daily walks. For me the multidisciplinary pain management program was a God-send; my enthusiasm for life is back. I still have pain every day. But I can cope with it now."

Peter, patient with permanent back injury through work accident at age 34

SUMMARY OF RECOMMENDATIONS

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Access to the Medicare Item number linked to accreditation (based on education and training)	12
Medicare funding for participation in **group pain management programs**, similar to Mental Health model	13
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Establishment of a certification, accreditation and funding process for **Pain Educators** similar to that of Diabetes Educators	14
Education and practical skills-based training for all health disciplines treating patients who live with chronic pain	15
Development of **chronic pain Health Pathways** with integrated links between primary, secondary and tertiary facilities by the new PHNs	16
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Health funds to support development of **system-based chronic pain management** model similar to Healthy Weight for Life program for OA	19
The **NSW ACI State-Wide Pain Plan** to be replicated in every Australian state and territory drawing upon on existing resources	20
Strategic approach to **funding data collection through the ePPOC** with federal and state government and private sector funder support	21
The **Central Coast Community-Based Pain Program** or similar programs, to be facilitated by the PHNs	25

BENEFITS TO STAKEHOLDERS

Our recommendations offer benefits to the following stakeholders:

Consumers – one in five people living with chronic pain, their families and carers:

- More effective prevention and management, including supported self-management of chronic pain, reduced reliance on medication, reduced need for surgery and referrals to other hospital-based health services.
- Improved function and decreased disability and its associated demands on family and carers.
- Ageing population will be able to continue as a more productive part of the workforce for longer and so become less of a burden on current pension or welfare systems.
- More affordable, better quality, accessible, patient-centred team-based care.
- Special programs for CALD and Indigenous communities.[106]

General Practitioners:

- Ability to achieve better outcomes for patients with chronic pain; reduced frustration associated with complex, difficult to treat patients.
- Ability to offer treatment which does not rely on potentially unhelpful medication with its related side-effects and potential harms including addiction.
- Ability to promote and facilitate better self-care; more confidence in referring to suitably qualified allied health professionals.

Nurses and Allied Health Practitioners (AHP):

- Ability to receive and provide referrals from GPs for patients with chronic pain as valued member of multidisciplinary team.
- Ability to receive MBS refunds for work done by accredited pratitioners.
- Optimum utilisation of AHP skills for best practice patient outcomes.

Public Hospitals:

- Significantly reduced waiting times at public hospital pain clinics including reduction in inappropriate referrals.
- Services are available to treat the most complex and difficult cases in a timely way.
- Reduction in harm-related presentations at emergency departments (opioid or other medication misuse or side-effects).

Private Pain Clinics and Service Providers:

- Ability to provide more affordable, best-practice pain management services, relieving the demand on public hospitals and emergency departments.

Employers and Workplace Insurers:

- Significantly improved return-to-work rates after injury.
- Reduced disability with associated reduction in compensation payments and insurance premiums.
- Reduced absenteeism, presenteeism and forced early retirement.

Government and Private Health Funders:

- Reduced demand for more expensive healthcare and surgical procedures.
- Reduced costs associated with rehabilitation and hospitalisation.
- Reduced emergency department admissions and medication use.
- Reduced welfare and disability support payments.

“Most people think arthritis is an older person’s disease, but kids get it too. Our son was just two years old when he was diagnosed with polyarticular juvenile arthritis. We have regular appointments with the GP, paediatrician, rheumatologist, occupational therapist, eye specialist, and the paediatric rheumatologist, which means a lot of expense and time off work.”

Scott who’s son Ronan lives with juvenile arthritis

IN SUMMARY

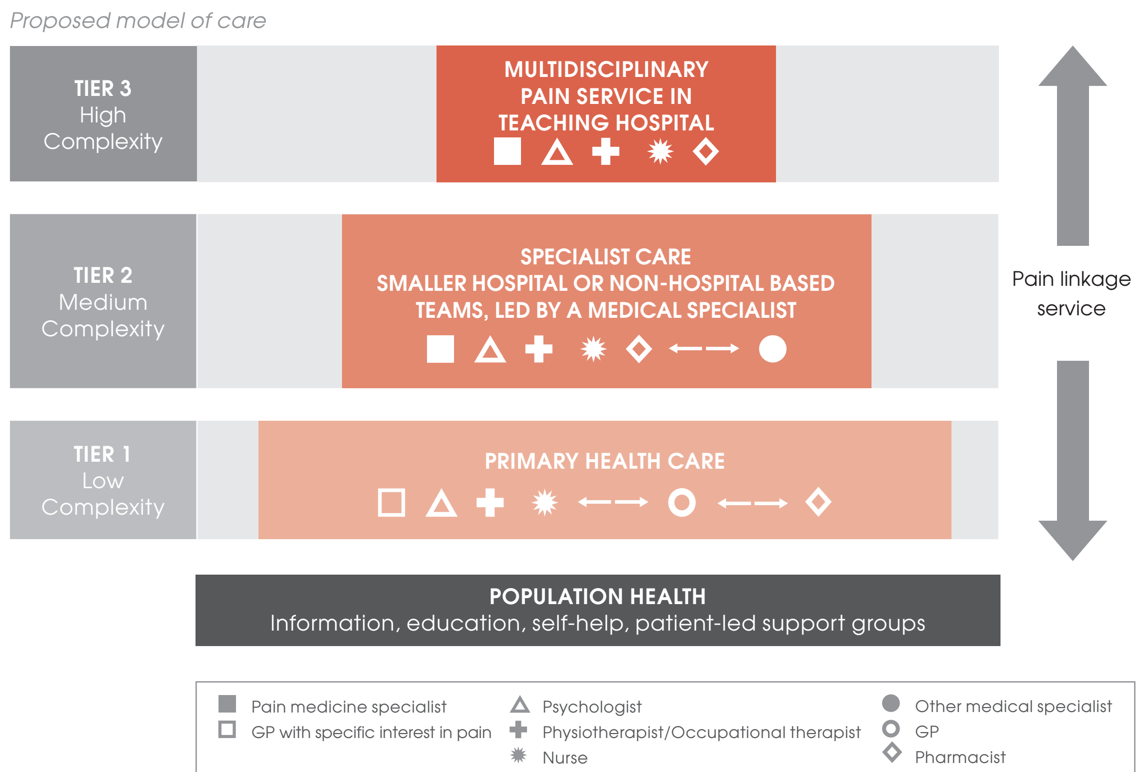
Our recommendations support the creation of funding mechanisms that encourage prevention, integrated care of chronic pain conditions and self-care to complement mechanisms designed for episodic acute care.

We are well aware of the need for fiscal constraint. Therefore our recommendations aim to utilise and enhance the expertise of existing primary healthcare professionals and, through training and appropriate incentives, equip them to better prevent and manage the widespread and increasingly costly health problem of chronic pain.

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

These are key recommendations of the National Pain Strategy 2010[107] and the NSW Health State-wide Pain Management Plan 2012[108] , currently being implemented through the NSW Agency for Clinical Innovation.[109] (See Figure 1 below)

FIGURE 1: NATIONAL PAIN STRATEGY MODEL OF CARE



See notes over:

The National Pain Strategy recommends that people living with pain have access to community-based multidisciplinary pain services, ideally, in the first instance with a locus around a suitably trained local GP. Primary care teams should be connected with and supported by specialist pain teams working in metropolitan and regional pain centres (public and private) 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 effective and can be facilitated by the Primary Health Networks, drawing upon the expertise of local, trained health professionals. See Figure 1.

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 the model eloquently (p.2).[110]

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"

We believe the health and economic benefits of our recommendations will benefit all Australian's

This submission draws upon the recommendations of the National Pain Strategy.

We thank Painaustralia members who contributed:

- Australian Pain Management Association
- Chronic Pain Australia
- Pain Management Research Institute, University of Sydney
- Physiotherapy Pain Collaboration

including teams working in primary care:

- Empower Rehabilitation
- Innovate Pain Management
- Innovative Rehab
- Central West Pain Specialists

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