



THE
AUSTRALIAN
PAIN SOCIETY

SUBMISSION TO THE PARLIAMENTARY INQUIRY

CHRONIC DISEASE PREVENTION AND MANAGEMENT IN PRIMARY HEALTH CARE

JULY 2015

Contact Details:

Dr Geoffrey Speldewinde
President
Australian Pain Society
C/- APS Secretariat
PO Box 637
North Sydney NSW 2059
T: (02) 9016 4343
E: aps@apsoc.org.au
W: <http://www.apsoc.org.au>

Lead Authors of this Submission:

Dr Geoffrey Speldewinde MBBS, FAFRM (RACP), FFPMANZCA, FAFMM
President, Australian Pain Society
Director, Capital Pain & Rehabilitation Clinic

Ms Fiona Hodson RN, BHSc
President-Elect, Australian Pain Society
Hunter Integrated Pain Service
NSW Agency for Clinical innovation (ACI)
Board Member, Chronic Pain Australia

Dr William Howard MBBS, FANZCA, FFPMANZCA
Secretary, Australian Pain Society
Director, Pain Service, Austin Health

President

Dr Geoffrey Speldewinde
Capital Pain & Rehabilitation Clinic
Deakin ACT 2600

President-Elect

Ms Fiona Hodson
Hunter Integrated Pain Service
John Hunter Hospital Campus
New Lambton NSW 2305

Secretary

Dr Will Howard
Department of Anaesthesia
Austin Health
Heidelberg VIC 3084

Treasurer

Dr Gavin Chin
Royal Darwin Hospital
Casuarina NT 0811

Australian Pain Society Limited

ABN 15 008 629 141

All correspondence to:

APS Secretariat
c/- DC Conferences Pty Ltd
PO Box 637
North Sydney NSW 2059
Australia
Tel: 02 9016 4343
Fax: 02 9954 0666
Email: aps@apsoc.org.au
Web: www.apsoc.org.au

SUMMARY

- The Australian Pain Society recognises the need for enhancement of combined and coordinated multidisciplinary care in the community across many disease groups. This approach optimises community participation and integration of the individual with their chronic disease, including chronic pain conditions.
- Informed management of pain conditions by a range of relevant Health Care Professionals utilising current best practice strategies in a combined and coordinated manner including where relevant access to Multidisciplinary Pain Management Programs have been shown to afford numerous benefits to a statistically significant degree across a range of areas including:
 - Increased work participation
 - Improved quality of life
 - Improved physical and psychological functioning with or without continuing pain
 - Judicious use of appropriate medications including reduced use of opiates; and
 - Decreased subsequent health care utilisation
- Opportunities to create these improvements include:
 - Maximising early access to multidisciplinary pain management
 - Education and liaison of multidisciplinary healthcare providers
 - Funding of allied health care interventions of sufficient duration to bring about change in chronic pain and other conditions
 - Remuneration for group or individual pain management programs
 - “Disease Educators” providing customised disease specific educational and triage sessions to small groups of people with chronic diseases such as persistent pain
 - Remuneration from pain medicine item numbers for consultations being made equal with those of other physicians
- Primary Health Networks could expand on targeted multidisciplinary education for patients to self manage their chronic pain such as has been undertaken through the Medicare Locals in Perth, WA
- We advocate setting up item numbers which remunerate the provision of both brief and extended multidisciplinary programs and which allow for the provision of both individual and group programs, depending on the needs and suitability of each patient.
- Sustained funding required for Electronic Persistent Pain Outcomes Collaboration (ePPOC) which collects pain data from 45 public hospitals in NSW, QLD, VIC and WA
- Disease specific education is required to improve prevention of complications and enhance efficient and effective patient self management of the chronic disease
- Priority should be given to developing co-ordinated groups of healthcare professionals:
 - with foreign languages; and
 - in rural centresto deliver the interventions described throughout this submission
- By aiming for optimal early assessment and intervention to prevent and manage chronic pain conditions across a wide variety of other diseases, we describe an effective and efficient pathway for sustained self management, ultimately consuming less health and welfare resources, while contributing to more workplace productivity and improved lifestyle outcomes in the community generally.



SUBMISSION TO THE PARLIAMENTARY INQUIRY

CHRONIC DISEASE PREVENTION AND MANAGEMENT IN PRIMARY HEALTH CARE

The Australian Pain Society (APS) makes this submission to the important, topical and potentially ground breaking inquiry of the Standing Committee on Health: “Chronic Disease Prevention and Management in Primary Health Care” (the Inquiry).

The Australian Pain Society submission will focus on the recognition and management of chronic pain. Traditionally, chronic pain has been considered to be a manifestation of disease but quite recently there has been a shift by many experts in this area to regard chronic pain as a disease in its own right; research has demonstrated genetic susceptibility to developing chronic pain, and pathophysiological processes specific to chronic pain (see below). Shared elements with other disease processes will be apparent in this submission.

The membership of the Australian Pain Society is drawn from a range of disciplines, including: clinical and laboratory researchers, medical doctors, nurses, occupational therapists, pharmacists, physiotherapists, psychologists etc. We aim to relieve pain and related suffering through leadership in clinical practice, education, research and public advocacy. Our vision is that all people will have timely recognition, prevention and management of pain across their lifespan. (See www.apsoc.org.au)

Chronic pain is prevalent in the Australian community affecting around 20% of our population on any given day (Blyth et al 2002). This is similar to the prevalence in other Western societies (Breivik et al 2006). Moreover it is a very costly disease through not only its need for treatment, but far more significantly because of its impact on work participation which limits the individual's income and requires that the individual is supported by society (directly by the Federal government or indirectly through work injury or motor accident insurance). The economic cost of chronic pain was estimated by Access Economics to be \$34 billion dollars in Australia in 2007 (MBF Foundation Report), with health expenditures for pain exceeded only by cardiovascular and musculoskeletal conditions. This is similar to that seen in Europe and the United States (see citations in Sletten et al 2015).

Pain has been defined as “an unpleasant sensory and emotional (and cognitive) experience associated with actual or potential tissue damage or described in terms of such by the patient” (International Association for the Study of Pain 1974). In recent decades there has been intensive research into pain using techniques which range from neural electrophysiology and biochemistry to functional brain imaging to behavioural studies. This work repeatedly demonstrates:

- that pain is not just a symptom but represents the innate brain and body responses to actual or potential harm to the organism
- there are measurable hormonal, inflammatory, immunological, and neurological responses
- which if left untreated result in long term neurological and behavioural changes

Although, pain – especially when chronic - is a disease with measurable phenomena e.g. neurophysiological, hormonal, and inflammatory markers, these tests are not routinely available. Furthermore, pain is a subjective phenomenon which is not visible. Therefore it can be difficult for pain to be validated by others causing sufferers of chronic pain to be stigmatised which compounds their distress and worsens their pain.

Many conditions causing chronic pain are not dealt with by medical treatment or surgery; indeed medical treatments and surgery can cause chronic pain. (For example, see Simanski 2014) The role of medications is limited by poor or partial efficacy and by excessive adverse effects including dependence and addiction (HIPS 2014). Thus satisfactory results in the management of chronic pain require a shift from expectation of a cure to one of optimising one's life despite continuation of the condition (as occurs in other chronic diseases). For some patients with chronic pain, this can be achieved relatively simply with a brief (several hours) educative process; others require more intensive interventions due to variables such as the duration of pain prior to these interventions, the nature of the pain, and psychosocial factors – usually the key intervention is a rehabilitation program founded on cognitive behavioural therapy.

In the Chronic Pain Australia (CPA) 2015 snapshot Living with Pain Survey, it noted that 76% of people chose to manage their pain with medication. There was a much lesser percentage of those who chose to use self management options such as lifestyle or physical management strategies (CPA 2015). We consider this most likely reflects lack of provision of suitable pain management programs, which causes patients and their doctors to rely excessively on medications but which fail to achieve improvements in overall quality of life and meaningful activity (a recurring pitfall).

It has been shown that having better informed patients leads to more cost-effective, patient-centred, and patient-driven management of their pain, utilising an expanding coalition of informed and coordinated health professionals (Turk et al 2002). Comprehensive Pain Rehabilitation Programs have been shown to “have a broader base of benefits and fewer overall costs relative to drug therapies, interventional pain therapies and surgery” (Sletten et al 2015).

The Australian Pain Society recognises the need for enhancement of combined and coordinated multidisciplinary care in the community across many disease groups. Such disease groups can include examples such as stroke, amputations, head injury, spinal cord injury, diabetes mellitus, and Parkinson's disease. One of the authors (Dr G Speldewinde), in his role as a specialist Rehabilitation Medicine clinician in private practice, has seen how these disease groups can be managed more efficiently and effectively within the community of the patient rather than in more dislocated hospital-based settings.

This approach recognises that chronic disease by its definition has already “happened” to the patient. However there are established and recognised strategies, many of which have been developed and run in hospital-based locations and research centres that show that an informed, combined and coordinated health work force can minimise, if not prevent, unnecessary long-term complications of the chronic disease processes whether it be chronic pain or other disease conditions.

Moreover such an approach has been shown to optimise community participation and integration of the individual with their chronic disease, including chronic pain conditions. This has been well recognised with diabetes mellitus and chronic renal failure as examples. Schofield et al have repeatedly demonstrated the economic argument overwhelmingly favouring effective and efficient management of chronic pain conditions for a greater effective and durable participation in our workforce. As the workforce ages and works for longer years this becomes even more important.

The following material is supplied in accordance with the Terms of Reference of the “Chronic Disease Prevention and Management in Primary Health Care” Inquiry of the Standing Committee on Health.

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

Early provision of a short (8 hours) program of education about chronic pain has transformed management of chronic pain. This was developed and implemented by Dr Stephanie Davies and colleagues in hospital-based clinics in Perth, WA. The program was called “Self Training Educative Pain Sessions (STEPS)”. STEPS taught pain knowledge including neuroplasticity, and skills such as pacing, pain approach, mindfulness, making sense of pain, and medical options. The key healthcare professionals were pain physicians, musculoskeletal physiotherapists, behavioural psychologists and occupational therapists. From 2007 to 2014 approximately 3000 patients attended the Fremantle Hospital STEPS program.

The results of STEPS were that about half of the patients who attended considered they no longer needed management by a pain clinic; those who still requested management by a pain clinic were better prepared for such management and were considered to achieve better outcomes after management by the pain clinic. (Davies 2011 and Davies 2015)

STEPS was adapted for use in the community and has been running through four Medicare Locals in and around Perth over the last 2-3 years. This has placed basic pain management education activity right back into the community.

We believe the majority of patients with chronic pain can be managed in the community. This will require community-based healthcare professionals - allied health and doctors – to be educated and trained in the management of chronic pain.

As described above, a significant proportion of patients will require more prolonged and intensive management within a multidisciplinary Pain Management Program (PMP). Such programs have been run successfully for over two decades and are typically based on the principles of cognitive behavioural therapy. Results indicate that PMP's afford numerous benefits across a range of areas including return to work rates (Haldorsen et al, 2002), physical and psychological functioning (Moreley, Williams & Hussain, 2008), quality of life, medication use and health care utilisation (Gatchel & Okifuji, 2006). Recently in the NSW Central Coast Medicare Local, they ran a pilot multidisciplinary PMP with improvement in clinical outcomes and patient satisfaction. Outcome data from this program will be available later in 2015.

Further a recent USA publication has reported the medical savings achieved by an intensive pain rehabilitation program: see Sletten 2015. Canada has some excellent chronic pain programs. One such program is supported by the Calgary Chronic Pain Service (CCPS). This Calgary Regional Pain Program includes the ‘Ambassador Program’ which enables GPs and other primary care providers throughout the province, to update their knowledge of evidence based medicine and chronic pain management. It also includes an educational program for the community called ‘Living Well with a



Chronic Condition program’.

<http://www.albertahealthservices.ca/services.asp?pid=service&rid=1005671>

This program contains generic chronic disease self management modules around exercise, nutrition and lifestyle management options as well as chronic pain specific material (Cousins 2009). These programs enable those people with chronic pain in rural and remote areas of the Calgary province to gain access to a local GP who is supported by a chronic pain specialist via telehealth and video conferencing. The success of these programs continues.

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

Well known predictors for a more prolonged and difficult pain condition, are a lack of early recognition of patients at risk of developing significant disability from chronic pain and the inability to implement early effective management of such patients.

- (i) Maximising early access to multidisciplinary pain management by informed educated health professionals working in a combined and coordinated manner will lead to earlier identification of people at risk and to commencement of appropriate management. We recommend modifying Medicare payment systems to reward and encourage this best practice. We consider this will play a valuable role in limiting the development of the multiple adverse consequences of having persistent pain (as with other persistent diseases).
- (ii) Secondly, we consider establishment and maintenance of such groups of suitably credentialed and empowered allied health and medical healthcare providers will require mentoring and liaison from experienced personnel in secondary and tertiary centres, whether the latter are drawn from the private or public systems. We recommend provision of Medicare funding (to enable such education and liaison) to remunerate all healthcare providers involved in this process. Education and liaison could include shared case conferences and audit, with participants meeting in the same setting or linked electronically e.g. teleconferencing.
- (iii) Thirdly we recommend Medicare funding of allied health interventions of sufficient duration to bring about change in the setting of a difficult condition – chronic pain. Enhanced Primary Care Plans and Mental Health Plans give patients a tantalising glimpse of better management opportunities but the cost of continuing involvement with providers of allied health care (such as occupational therapists, physiotherapists, psychologists) beyond the allowance of these plans precludes establishing meaningful therapeutic relationships and bringing about enduring changes in patients’ ability to self-manage their condition. Commonly this leads patients back to hospital-based and hospital-funded settings to obtain treatment. For many patients, there is little that is undertaken in hospital-based pain clinics, particularly for sufferers of non-cancer pain, which cannot be undertaken in a range of community settings with well supported and educated clinicians. Obtaining access to hospital-based treatment usually causes delay in treatment, which results in the patient developing problematic sequelae of chronic pain (such as deterioration in mental health, severe physical

deconditioning, helplessness and demoralisation.) In contrast, management within their own community is expected to produce better engagement with therapy and better results for the patient.

Such involvement should reasonably be funded over a total of 15-30 sessions shared between the various therapists, rather than the current availability provided through the Enhanced Primary Care plans that currently provide a valuable but very limited mixture of up to 5 such sessions in a calendar year. Five sessions does not provide sufficient duration of therapies to develop self-management techniques. It can provide useful opportunities for maintenance of minor aspects, but not the major aspects, of persistent disease conditions which impact negatively on quality of life, including domestic, social and occupational function.

A prerequisite for such extended management by AHPs should be case conferences between the participating AHPs and the patient's referring doctor. Management goals should be defined and recorded at the outset, and outcomes measured following completion of interventions. To lessen the burden of compliance and record keeping, it is recommended that brief questionnaires and 'pro forma' management plans are devised. The Australian Pain Society could assist in devising this. All such records should be electronic.

- (iv) Group management is often valuable in these situations. To optimise outcomes for the patient, remuneration should be set up so that it is comparable whether interventions are done on a group or individual basis.
- (v) There is a role for a greater use of trained "Disease Educators" providing customised disease-specific educational and triage sessions to small groups of people with chronic diseases such as persistent pain. For persistent pain conditions, this "Pain Educator" will facilitate an expanded awareness and insight into the possibilities of more effective and efficient long-term self-management by that patient. This will then lead the patient with chronic pain (or with many other types of chronic disease) to a more effective and informed utilisation of a broad range of health resources, resulting in reduced long term use of health resources as the patient gains an improved level of understanding of the nature and management of their condition, develops reasonable expectations and goals, and then implements self-management strategies. Many chronic disease prevention and management strategies overlap with lifestyle and activity modifications along with specific educational requirements unique to each disease state. Therefore we recommend establishment of Medicare items for activities by "Disease Educators"
- (vi) The fellowship of the Faculty of Pain Medicine is a second fellowship with the pre-requisite that candidates must already hold a primary fellowship in any discipline (such as anaesthesia, general practice, psychiatry, rehabilitation medicine) and must undertake at least two years training in pain medicine as well as an intensive process of appraisal and examination. Specialists in pain medicine perform comparable work when consulting but currently item numbers discriminate between those who hold primary fellowships in specialties drawn from the Colleges of Physicians and Psychiatry versus those from other specialties such as Anaesthesia, General Practice or Surgery. Consequently the

remuneration for pain medicine consultations performed by the latter group is less than half that of pain medicine specialists with primary fellowships as a physician or psychiatrist. This acts to: deter recruitment from the specialties of anaesthesia, general practice and surgery; and to bias their practice away from performing consultations and subsequent preparation of management plans to be used by the patient's healthcare practitioners - general practitioners and allied health personnel. We recommend that the remuneration from pain medicine item numbers for consultations is made equal with those of other physicians.

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

The next phase that the Australian Pain Society recommends is the more general availability of community-based (rather than Hospital-clinic focussed) allied health professionals (AHP) able to nurture and maintain the impetus for self-management that patients can gain from multidisciplinary education. These "pods" of AHPs with specific expertise for specific disease groups whether it be persistent pain, stroke, Parkinson's disease etc. would be developed through each Primary Health Network recognising the health needs of their local populations and developing the resources to manage their priority areas.

As mentioned in terms of reference item 1 above, there has been limited delivery of brief (about 8 hours) educative programs (about pain and its management) by community-based, not hospital-based, healthcare providers. As for the management of any chronic condition, these educative programs have as their goal, the patient becoming competent in long term self management. Such programs were implemented in a small number of Medicare Locals - for example in four Medicare locals in the Perth region over the last several years. Hopefully this will continue as these Medicare Locals amalgamate into Primary Health Networks and we consider that it is highly desirable that similar programs are implemented throughout Australia.

This can lead to enhanced workplace participation and reduced use of health resources whether it be of medical personnel, pharmaceuticals or AHPs. This targeted education has been shown to align with major patient satisfaction and overall improved quality of life as demonstrated by the work that has been undertaken through the Medicare Locals in Perth.

As discussed earlier there is a need for a new sub-specialty of Allied Health Professional Educators in pain, or perhaps more generally, chronic disease. This would ideally come from various clinical groups familiar with different aspects of the management of persistent diseases, rather than de novo with a Health Education specialty degree. The clinical experience of experienced AHPs or medical doctors conveyed to the patient is invaluable and cannot be underestimated. As described above (in section 2), we consider it is highly desirable that strong linkages are established between primary care and the expertise located in secondary and tertiary centres, whether private or public. Development of expertise could occur by mentoring, joint case conferencing and audit.

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

Some private health insurers incentivise their clients to better understand and self-manage their chronic disease by funding small aliquots of education about disease management. However this is generally not well advertised and is buried away in the item numbers for psychologists and physical therapists. The insurance cover depends on the training and experience of each such clinician and the specific educational content of consultations.

Funding of items for attendance at group based educational sessions for management of chronic pain or other diseases would be invaluable as a long-term strategy for the prevention of the range of complications that can arise from chronic persistent disease conditions including persistent pain. Groups are recognised to be powerful mediators of change in individuals, but currently remuneration systems limit their use in private practice.

As stated above (in item 2), we advocate setting up item numbers which remunerate the provision of both brief and extended multidisciplinary programs and which allow for the provision of both individual and group programs, depending on the needs and suitability of each patient.

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

In NSW, the Agency for Clinical Innovation (ACI), Pain Network has facilitated the development and implementation of a comprehensive State-wide Pain Plan and Model of Care (MOC). The aim of the Pain Management MOC is to provide equitable and evidence-based services that improve quality of life for people living with pain and their families, and to minimise the burden of pain on individuals and the community. Further, the model of care aims to integrate care across all aspects of the health care system by increasing partnerships and the capacity of Pain Management Services.

As part of enhanced funding for the MOC, the ACI Pain Network provided education, training and support for health professionals working in primary care to enable them to better manage patients with chronic pain in the community sector instead of them being referred to a tertiary pain clinic. Part of this strategy was the development of a pain management website that targeted health professionals and consumers with pain related tools and resources www.aci.health.nsw.gov.au/chronic-pain.

Seed funding around continuous evaluation and reporting was also part of the NSW Pain MOC on the effectiveness of pain programs as the basis for continuous improvement and identification of best practice. This enabled the establishment of the Electronic Persistent Pain Outcomes Collaboration (ePPOC). Pain data is now collected from 45 public hospitals in NSW, Queensland, Victoria, Western Australia and New Zealand, funded by state governments and NZ Health. <http://ahsri.uow.edu.au/eppoc/index.html> (See also item 7 re ePPOC)

Key outcomes from this NSW Pain initiative has been an increased number of pain programs delivered to people in NSW and a reduction in waiting time for the majority of

NSW Pain Management Services along with significantly improved patient satisfaction (ACI 2014).

South Australian Health is in the very early stages of developing a state-based 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.

A major gap in any current Pain MOC in Australia is the lack of uptake of existing education, training and resources by GPs and other health professionals. Uptake is much improved with suitable funding models and incentives for them in clinical practice as evidenced in NSW MOC evaluation (ACI 2014)

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

The evolving approaches for the management of chronic pain conditions are based on there being a more informed and insightful patient group who understand their chronic pain condition more profoundly than otherwise. This understanding can then lead these patients to achieve goals that are important to them as individuals. This enhances their motivation when they take on a treatment program which they have helped devised themselves with counsel from informed allied health professionals and medical doctors.

The success of this approach has been exemplified by improvement in clinical outcomes achieved through hospital-based pain clinics such as the Fremantle pain clinic under Dr Stephanie Davies, and the Hunter Integrated Pain Service under Dr Chris Hayes. Their work has emphasised that the results that they have achieved can be, and are being, replicated by utilising their innovative models of service delivery within the community, outside of tertiary hospital pain clinics. This has been achieved with internationally recognised research developed and progressed in Australia, and is thus contextually relevant and proven in the Australian social and political environment.

In a private setting in Canberra, at the Capital Pain and Rehabilitation Clinic, clinicians have replicated and verified the value of patient education and have shown a statistically significant improvement in pain, physical activity and psychological function simply by providing a 2 hour introductory pain educational session run by an informed pain counsellor as educator. This, along with much of the work of Drs Davies and Hayes, has been presented at annual scientific meetings of the Australian Pain Society. The work of the latter two doctors has been published in international peer-reviewed literature. (Davies 2011 and Hayes & Hodson 2011)

It would be of interest to compare the effectiveness of this approach of assisting patients manage their chronic pain disease with the approaches taken with other chronic disease groups from which no doubt submissions will be received. We expect that the need for disease-specific education will be a common theme amongst many chronic disease groups to improve prevention of complications and enhance efficient and effective management of the chronic disease.

The Australian Pain Society has been a keen sponsor of the establishment of a quality improvement strategy - ePPOC, the electronic persistent pain outcomes collaboration register. The intent of this register is to enable individuals and units, which provide

management of chronic pain, to compare their patients and their outcomes using an anonymous register operated by the University of Wollongong. Where results are significantly below those of better performing individuals and units, the under-performers may voluntarily seek advice to explain and remedy their poor performance. (Comparable systems already exist in rehabilitation medicine and in palliative care.) ePPOC is currently in its development phase. Assuming the trial of ePPOC indicates that it is desirable that it is continued, then funding will be required to cover the costs of providing data to the register, processing the data, and maintaining the register. We advocate that continuation of ePPOC is ensured by provision of ongoing funding from the Federal Government and state governments.

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

As a consultant in Rehabilitation and Pain Medicine, Dr Speldewinde has long worked in a multidisciplinary team environment including in his private multidisciplinary pain and rehabilitation clinic. Over the decades he has grown in his appreciation and understanding of the value of a multidisciplinary environment working in a combined and coordinated manner and providing a consistent and persistent theme that is evident to the particular individual patient and their social environment including family and work. There is no surer way of providing a unified approach with the same messages, goals and values than when the team is working in the same physical environment, with patient-centred care at its core.

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

As described above, we consider data indicates that, following a brief pain education program of about 8 hours, around 50% of people with chronic pain will change their expectations of a “medical answer” to their disease (chronic pain) and there will be a commensurate decrease in their use of medical services.

Not all patients with chronic pain can be managed in primary care. Some have complex diseases, others have severe psychiatric issues, and others have addiction problems, which require the involvement of hospital-based services. Such patients can cause a considerable burden in any location and can be particularly problematic in primary care clinics. It is important that suitable resources and facilities are in place for these situations. These patients are best managed through involvement of hospital-based services, i.e. in specialised appropriately resourced and supported pain management services in tertiary referral centres. Whilst these need not be in hospital clinics, it is likely that outcomes would be more predictably effective in an environment with skilled practitioners able to access a variety of resources not commonly available in primary health care. Such resources may include access to a psychiatrist, substance abuse clinics, and other specialist health professionals. Compared to the high prevalence of patients with chronic pain, these complex patients are a relatively small minority.

Other comments

We suggest these areas also need consideration:

a) Language barriers

The model of care depends on very good communication between healthcare providers (HCPs) and patients. When patients do not have English as their first language, this is usually a considerable challenge. We strongly recommend that the Inquiry considers how to optimise provision of translation to meet this challenge. It is very desirable that there is a medically trained interpreter facilitating interaction between the HCP and the patient. Clearly, the economic efficiency of such interactions can be considerably improved by using interpreters in situations of group education and group rehabilitation programs such as has been described above. Further the Inquiry should note that involvement of interpreter services (in whatever form) more than doubles the time involved for the interaction: this should be recognised in the remuneration of HCPs when translation occurs.

Alternatively, it should be noted that the challenge of language (and associated cultural barriers) can be circumvented by utilising healthcare professionals, medical and allied health, in the community who speak the language. Therefore priority should be given to developing co-ordinated groups of healthcare professionals with foreign languages to deliver the interventions described throughout this submission. Our proposal regarding training and mentoring of such groups is described in section 2 (ii) above.

b) Geographical barriers

In this submission, we have emphasised the value of developing the capacity of primary care-givers to provide management of chronic pain: as well as having the potential to deliver early and therefore more effective intervention to prevent the consequences of poorly managed chronic pain, attending an HCP in primary care is expected to avoid the geographical challenges of attending services in secondary and tertiary centres. Analogous to the situation with a language barrier, geographical barriers should be dealt with by giving priority to developing co-ordinated groups of healthcare professionals in rural centres to deliver the interventions described throughout this submission. Our proposal regarding training and mentoring of such groups is described in section 2 (ii) above. However, it is the experience of members of the APS that Telehealth has been under-utilised. Barriers include: failure of provision of suitable facilities; lack of suitable software or failure to provide such software to providers of healthcare; poor remuneration and cumbersome bureaucracy. Correction of these problems will assist achieving training and mentoring of HCPs.

When involvement of secondary and tertiary centres is required, there should be provision of reliable and free transport to ensure the patient can attend appointments.

Also provision of suitable accommodation should be ensured to ensure that patients who live distant from a secondary or tertiary centre can attend appointments, education programs and pain rehabilitation programs.

Conclusions

The Australian Pain Society in this submission has shown that there are likely to be common elements involved in the better prevention and management of chronic disease in the Australian community.

The likely common elements as they pertain to the management of chronic pain include:

- **A combined and coordinated group** of relevant, informed, and interested sub-specialised Allied Health Professionals with medical practitioners also specialised in the recognition, prevention and management of conditions of pain as a disease.
- Recognition of the growing importance of **Pain Educators** derived from relevant health professionals with further specific specialised training in the disease of acute and persistent pain whether of non-cancer or cancer origin.
- For purposes of modifying behaviours, improving the patient's beliefs about their pain, addressing stressors, improving physical function despite continuing pain, and increasing the likelihood of improved participation and productivity within the work force over a longer duration, there is strong evidence that patients with chronic pain are **far more effectively treated with a sustained duration of involvement** with a relevant team of multidisciplinary health professionals. Such involvement is far more likely to be productive over a 3-6 month period of programmed diminishing frequency of therapy sessions rather than over a 3-6 week period, and certainly not a 3-6 day period.
- By aiming for optimal early assessment and intervention to prevent and manage chronic pain conditions across a wide variety of other diseases, we describe an effective and efficient pathway for sustained self-management, ultimately consuming less health and welfare resources, while contributing to more workplace productivity and improved lifestyle outcomes in the community generally.

References

Access Economics, The high price of pain: the economic impact of persistent pain in Australia. November 2007. MBF Foundation.

Agency for Clinical Innovation (ACI), Formative evaluation of the ACI model of care, http://www.aci.health.nsw.gov.au/_data/assets/pdf_file/0004/263308/Formative_Evaluation_of_the_ACI_Pain_Management_model_of_care.pdf, 2014, ACI.

Breivik H et al, Survey of chronic pain in Europe; prevalence, impact on daily life, and treatment Eur J of Pain 2006; 10: 287-333

Cousins, M., Australian National Summit fact finding visits to USA, Canada and UK: Report on key findings and associated resource materials, 2009.

Chronic Pain Australia (CPA), Living With Pain – Snapshot Survey 2015, Viewed: <http://www.nationalpainweek.org.au/index.php/survey>, CPA

Davies S et al, Preclinic group education sessions reduce waiting times and costs at public pain medicine units Pain Medicine 2011; 12: 59-71

Davies S, Whole person engagement for the treatment of chronic pain Australian Pain Society Newsletter 2015; 35(4) June: 5-7

Hayes C and Hodson FJ, A whole person model of care for persistent pain: from conceptual framework to practical application Pain Medicine 2011; 12: 1738-1749

Hunter Integrated Pain Service (HIPS), Reconsidering opioid therapy-A Hunter New England perspective, May 2014, HIPS

Merlin JS et al, Pain Self-management in HIV-Infected individuals with Chronic Pain: A Qualitative Study. Pain Medicine 2015, 16: 706-714

Peppin JF et al, The Complexity Model: A novel Approach to Improve Chronic Pain Care. Pain Medicine 2015; 16:653-666.

Schofield D, Med J Aust 2008; 189(8): 447-450

Simanski CJ et al, Pain Medicine 2014; 15: 1222-

Sletten CD et al, Economic Analysis of a Comprehensive Pain Rehabilitation Program: a Collaboration between Florida Blue and Mayo Clinic Florida. Pain Medicine 2015, 16:898-904