UMG Submission 74

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SUBMISSION: BUSINESS PLAN FOR PAIN MANAGEMENT SERVICES IN WESTERN AUSTRALIA

19 October 2010

To: Hon Dr Janet M. Woollard, MLA

Chair, Education and Health Standing Committee

Legislative Assembly of Western Australia

Supplementary submission by;

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Appeared before the EHSC Committee on 2 September 2010

Request by the Chair, Dr Janet Woollard, MLA, to draft a business plan for the provision of optimal pain medicine services in Western Australia over the next 5 years, in context of reducing the burden of prescription opioid and over-the-counter analgesia abuse, addiction, and other drug and alcohol related impacts of sub-optimally-treated chronic pain in the Western Australian community.

SUMMARY

The amount of additional funding required for optimization of pain services in WA (excluding set up infrastructure costs), and *not* including the cost of community opioid prescribing (CPOP), prescription monitoring systems & public education campaign (see below) is estimated at;

$9 780 000 pa

If WA were funded based on the Queensland state government's formula (per capita, per annum) for additional funding for pain services in 2010 (see below);

The amount of additional funding required for optimization of pain services in WA is;

$4 965 918 pa

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INTRODUCTION

NB: please read in conjunction with my transcribed testimony of 2 September 2010, which includes supportive evidence for statements in this submission.

Chronic pain is an under-recognised but prevalent chronic health care problem affecting 20 percent of the Western Australian community. A substantial proportion of Western Australians with chronic pain have drug and alcohol-related problems, including the use of alcohol, tobacco and cannabis. However, there is increasing 'epidemic' of prescription opioid and over-the-counter analgesic abuse, with the majority of those affected having accessed these analgesics initially for chronic pain management.

As outlined in my submissions and testimony, my profession's concerns about prescription opioid abuse, especially in context of sub-optimal chronic pain management were recently highlighted in an ABC Four Corners programme "Oxy: The Hidden Epidemic" (Reporter: Matthew Carney) broadcast on 23/09/2010 http://www.abc.net.au/news/video/2010/09/27/3023252.htm which I strongly recommend the Committee members watch.

I appreciated the Committee's insights and proposal that optimising the treatment of chronic pain in the WA community will reduce the burden of associated drug and alcohol problems, in particular the abuse of prescription opioids. In addition to reducing pain-related drug and alcohol abuse, the optimal treatment of chronic pain is a worthy and necessary goal, as recognised by the Queensland state government this year, with the allocation of a *39.1 million dollar funding package* for pain management. http://www.cabinet.qld.gov.au/MMS/StatementDisplaySingle.aspx?id=70083

KEY MESSAGES OF THIS SUBMISSION

1. **Provide funding to optimise and expand tertiary level multidisciplinary pain management centres in the metropolitan area;** including clinical and allied health services, comprehensive pain management programmes and pain management interventions, liaison with drug and alcohol services ('hub').

2. **Provide funding to expand services in outer metropolitan secondary hospitals** (community based); mainly clinics, introductory patient-centred education programmes, allied health services, rehabilitation, liaison with drug and alcohol services ('hub').

Total cost for 1+2 (staff salaries) $6 940 000 pa

3. **Provide additional funding for *introductory patient-centred pain education programmes* such as STEPS (FHHS) and IPM (SCGH), in addition to established comprehensive pain management programmes.**

Total cost (staff salaries) $1 400 000 pa

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4. **Provide funding to enhance and expand services to rural and remote patients** with chronic pain and drug and alcohol problems, by expanding *Telehealth* and outreach programmes to patients and health care professionals (possibly via the 'Royalties for Regions' scheme)?

Total cost (staff salaries) **$200 000 pa**

One-off infrastructure costs **$100 000**

5. **Provide funding to establish a combined pain medicine and drug and alcohol management programme** for the timely and comprehensive review of complex patients with chronic pain and substance abuse problems. **Total cost (staff salaries)** **$400 000 pa**

6. **Provide funding for a real-time, computerised monitoring system for opioid prescribing and dispensing** (similar to the pseudoephedrine monitoring system currently operating in pharmacies); real time access to 'doctor shopping' hotlines and WA DoH Department of Pharmaceutical Services (monitoring schedule 8 drugs). **Total cost: unable to provide.**

7. **Provide enhanced funding for the Community Programme for Opioid Pharmacotherapy** (CPOP), making it more accessible and totally *cost free* for patients who required supervised dispensing of opioids for pain or substance abuse. **Total cost: unable to provide.**

8. **Difficulties with recruitment and retention of specialised staff:** There is very limited staff availability in pain medicine and related allied health professions; there are also very limited, funded training positions available in these professions (pain medicine, psychology, physical therapies and nursing). Pain management and addiction medicine are not seen as an 'attractive' specialties for health care professionals, as the remuneration is relatively low and the work is seen a complex and stressful.

Incentives such as salaries loading or 'waiting list' schemes (eg. after hours) may be required to attract and retain these highly trained and specialised staff. This precedent was set in other areas of unmet need such as psychiatry and radiology, where recruitment and retention of staff was a problem.

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CONCLUSION

The amount of additional funding required for optimization of pain services in WA (excluding set up infrastructure costs), and *not* including the cost of community opioid prescribing (CPOP), prescription monitoring systems & public education campaign (see below) is estimated at;

$9 780 000 pa

QUEENSLAND STATE GOVERNMENT FUNDING FOR PAIN SERVICES

COMPARISON WITH THE RECENT ADDITIONAL FUNDING FOR PAIN MEDICINE SERVICES BY THE QUEENSLAND STATE GOVERNMENT ($39 100 000)

Interestingly, in gross terms, our proposed funding figure for WA (4 years @ $ 9 780 000 = $39 120 000) is similar to the 4 year funding for pain management provided by the Queensland State Government in 2010.

Per annum:

Qld: $39 100 000/4 years = $9 775 000 pa

WA: = $9 780 000 pa

Per Capita* (population-ABS June 2009)*:

Qld: $9 775 000/4 406 800 = $2.22 per person/pa

WA: $9 780 000/2 236 900 = $4.37 per person/pa

If WA were funded as per the Qld state government's formula (per capita, per annum basis):

$2.22 x 2 236 900 = $4 965 918 pa

The amount of additional funding required for pain services in WA per annum is;

$4 965 918 pa

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DETAILS

1. FUNDING TO OPTIMISE AND DEVELOP MULTI DISCIPLINARY TERTIARY PAIN MEDICINE CENTRES ('HUBS')

- Fremantle Hospital and Health Service/Fiona Stanley Hospital/State Rehabilitation Service (future Murdoch Campus) (South Metropolitan)
- Sir Charles Gairdner Hospital (North-Central Metropolitan)
- Royal Perth Hospital (South-Central and East Metropolitan)
- Joondalup Health Campus ('High'-North and East Metropolitan) (area of unmet need; not yet established).

Outer metropolitan pain outreach programmes ('hub and spoke' design).

- Rockingham General Hospital
- Midland Health Campus
- Armadale Health Service
- Osborne Park Hospital
- Bentley Health Service

A. **Staffing and salaries** (state wide-over 4 tertiary campuses, 'spoke' campuses, rural and regional)

a) Need an additional 8 pain medicine specialists (1.0 FTE)

(AMA WA industrial agreement 2008 WA)

Salary: 8 x 320 000 **2 560 000**

b) 4 additional pain medicine training positions (senior registrar grade) (1.0 FTE)

Salary: 4 x 125 000 **500 000**

c) 8 additional clinical psychology positions (HSU award 2006 senior grade) (1.0 FTE)

Salary 8 x 90 000 **720 000**

d) 8 additional physical therapists (HSU award 2006 senior grade) (1.0 FTE)

Salary 8 x 90 000 **720 000**

e) 8 additional nurse practitioners (acute and chronic pain services) (SRN level 4) (FTE 1.0)

Salary: 8 x 90 000 **720 000**

f) Total of 2.0 FTE psychiatry or other medical specialties

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(AMA WA industrial agreement 2008 WA)

Salary total: 640 000 **640 000**

g) 2 Drug and Alcohol Specialists (FTE 1.0)

(AMA WA industrial agreement 2008 WA)

Salary: 2 x 320 000 **640 000**

h) 8 Administrative and secretarial staff (FTE 1.0) (HSU Award 2006)

Salary: 8 x 55 000 **440 000**

B. **Tertiary pain medicine centre facilities** (note some of this infrastructure is already available at some centres)

- Fremantle Hospital and Health Service/Fiona Stanley Hospital/State Rehabilitation Service (future Murdoch Campus) (South Metropolitan).
- Sir Charles Gairdner Hospital (North-Central Metropolitan)
- Royal Perth Hospital (South-Central and East Metropolitan)
- Joondalup Health Campus ('High'-North and East Metropolitan) (area of unmet need, not yet established).

a) Office space per tertiary pain centre: 5 consultants (can also be used for consultation and *Telehealth*), 2 trainees, 3 nurses, 4 psychologists, 4 physical therapists, 4 administrative staff.

Estimated total required =15 office units per tertiary centre (cost?)

b) Procedure theatre x 1 per tertiary pain unit (full operating theatre specifications)

Estimated total required: 1 procedure theatre per tertiary centre (cost?)

c) Recovery room **Estimated total required: 1 recovery room per tertiary centre (cost?)**

d) Patient waiting room **Estimated total required: 1 waiting room per tertiary centre (cost?)**

e) 2 large patient education and training rooms for pain programmes (also staff common rooms)

Estimated total required: 2 common rooms per tertiary centre (cost?)

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C. Hub and spoke infrastructure

- Rockingham General Hospital
- Midland Health Campus
- Armadale Health Service
- Osborne Park Hospital
- Bentley Health Service

Utilise existing facilities: consultation rooms, physical therapies and mental health and rehabilitation services available at these sites.

2. **A COMBINED PAIN MEDICINE AND DRUG AND ALCOHOL MANAGEMENT CLINIC**

This is a vital concept, to allow timely access to patients with combined pain and drug and alcohol problems.

Benefit: *to improve management of patient in pain with drug and alcohol problems, support GPs, and reduce the burden of opioid and substance abuse.*

A. Staff Requirements:

a) 4 sessions per week (0.4 FTE) pain medicine specialist

b) 4 sessions per week (0.4 FTE) drug and alcohol specialist

c) 4 sessions per week allied health professional (0.4 FTE) eg. psychology, drug and alcohol nurse, social worker etc

Cost: (staff salaries: estimated) **400 000**

5. REAL-TIME OPIOIDS SCRIPT MONITORING SYSTEM (similar to system for pseudoephedrine dispensing in pharmacies)

Benefit: *reduction in opioid and other prescription abuse, diversion.*

Cost: **I am not able to estimate this cost.**

6. **COMMUNITY PROGRAMME FOR OPIOID PHARMACOTHERAPY (CPOP)**: Enhancement of the current service, to provide access for pain patients with drug and alcohol problems who need daily supervised dispensing of their opioids. This needs to be a ***cost free system*** as many disadvantaged patients cannot afford the pharmacy dispensing fees (eg. methadone dispensing).

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Benefit: *reduction in opioid and other prescription abuse, diversion.*

Cost: **I am not able to estimate this cost.**

7. TELEHEALTH FUNDING FOR REMOTE AND RURAL PATIENTS: Consultations by medical and allied health, patient pain and drug and alcohol education programmes and health care professional education. *Telehealth* is an ideal medium for this, especially for rural and regional communities where opioid and substance abuse is quite prevalent.

Benefits: *improved access to services by rural and regional patients (reduce their disadvantage); reduces waiting list burden in the 'hub and spoke centres'.*

Cost: over 4 centres (staff; including clerical, technical) (FTE 0.4) **200 000**

Cost: infrastructure: (one off) **100 000**

8. ADDITIONAL FUNDING FOR *INTRODUCTORY PAIN MANAGEMENT PROGRAMMES* SUCH AS 'STEPS' AND 'IPM' (Introduction to Pain Management) at SCGH

Comprehensive programmes such as PUMP (FHHS), LEAP (RPH) and SCAMP (SCGH) are costed in 1 + 2.

Benefit: *STEPS (Self Training Educative Pain Sessions) is an evidence-based, patient-centred, 2 day education programme (based at Fremantle Hospital and Health Service and other pain centres) to help improve patient pain outcomes and reduce the waiting list times (thereby improving patient access). Drug and alcohol issues including opioid abuse are discussed in detail. A trial was funded by the Western Australian State Health Research Advisory Council (SHRAC) which demonstrated cost savings and reduced waiting list numbers and times (see submitted paper by Davies et al., 2010).*

Cost: *brief introductory programmes* in tertiary and other centres (staff, including clerical and research audit); *4 extra 2 day programmes per week.*
4x **350 000** **1 400 000**

9. RESEARCH AND AUDIT & SAFETY

Medical academic position (FTE 1.0); allied health academic positions (3 x FTE 1.0), administrative and data (2.0 FTE)

Benefit: *enhances evidence-based practice in pain medicine and drug and alcohol issues, audit and safety data and clinical indicators analysis.*

Cost: (staffing) **740 000**

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10. RURAL AND REMOTE CLINICS AND EDUCATION SESSION FOR GPS, ALLIED HEALTH AND PATIENTS

Benefit: *improve care of rural and remote patients with pain and drug and alcohol problems, also educating isolated health care practitioners. Prescription opioid abuse is particularly prevalent in regional centres where illicit drugs such as heroin are less available.*

4 x 2 day sessions, per year

Cost: staff, travel and accommodation **400 000**

11. PUBLIC EDUCATION AND ADVERTISING CAMPAIGN about chronic pain and prescription substance (opioid) and over-the-counter analgesia abuse.

Benefit: *Increase public awareness that prescription opioid abuse is the third most prevalent substance abuse problem in our community, after tobacco, alcohol, cannabis (psycho-stimulants), highlighting the risks of these problems in patients who have poorly managed pain.*

Cost: **I am unable to estimate.**

CONCLUSION

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If WA were funded based on the Queensland state government's formula (per capita, per annum) for additional funding for pain management services in 2010 (see below):

The amount of additional funding required for optimization of pain services in WA is;

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Addendum

Please note; the above listed costs are estimates only for the operation of 4 tertiary pain medicine centres providing comprehensive state-wide services over 1 year, not including any infrastructure costs. The author is not responsible for errors in cost calculations or estimates.

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Professional support of this document.

This document has the support and approval of the current Chair of WA regional committee of the Faculty of Pain Medicine, Dr P Max Majedi and the Heads of pain services at FHHS, RPH, SCGH and JHC.

Declaration of interests

The author of this document, Dr Eric J Visser, is a consultant at the Fremantle Hospital and Health Service (public service appointment) and Joondalup Health Campus and is a co-author of the STEPS study referred to in this document. He has no financial or other conflicts of interest in promulgating this submission. He submits this document as the immediate past Chair of the WA Regional Committee of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists.

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