

Public Submission Cover Sheet

Please complete this sheet and submit with any attachments to the Sustainable Health Review Secretariat

Your Personal Details

This information will be used only for contacting you in relation to this submission

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Publication of Submissions

Please note all Public Submissions will be published unless otherwise selected below

- I do not want my submission published
- I would like my submission to be published but remain anonymous

Submission Guidance

You are encouraged to address the following question:

In the context of the Sustainable Health Review Terms of Reference listed below, what is needed to develop a more sustainable, patient centred health system in WA?

- Leveraging existing investment in Primary, Secondary and Tertiary healthcare, as well as new initiatives to improve patient centred service delivery, pathways and transition;
- The mix of services provided across the system, including gaps in service provision, sub-acute, step-down, community and other out-of-hospital services across WA to deliver care in the most appropriate setting and to maximise health outcomes and value to the public;
- Ways to encourage and drive digital innovation, the use of new technology, research and data to support patient centred care and improved performance;
- Opportunities to drive partnerships across sectors and all levels of government to reduce duplication and to deliver integrated and coordinated care;
- Ways to drive improvements in safety and quality for patients, value and financial sustainability, including cost drivers, allocative and technical efficiencies;
- The key enablers of new efficiencies and change, including, research, productivity, teaching and training, culture, leadership development, procurement and improved performance monitoring;
- Any further opportunities concerning patient centred service delivery and the sustainability of the WA health system.

Submissions Response Field

Please type your response into the field below. Alternatively you may provide your submissions as a separate attachment (Suggested Maximum 5 pages).

Submission to the WA Sustainable Health Review October 2017

Further Development of Services for Management of Patients with Chronic Pain and Related Disability.

Chronic pain affects 20% of the adult population, 10% of the paediatric population and is a leading cause of disability, loss of quality of life and health and economic cost to the community.

Pain is by far the most frequent presenting symptom initiating health service interactions.

During the last 10 years or so health costs in Western Australia have more than doubled, far outpacing a population increase of one third and yet the chronic pain disability problem has if anything increased in magnitude.

Clearly current treatment approaches have largely failed to deliver outcomes and value for money.

At present patients whose primary problem is chronic pain related disability are initially and predominantly managed by biomedically framed services offering passive interventions such as surgery and hands-on therapy and medication based management.

It is known that a significant proportion of current biomedical based medicine is not adequately evidence-based and the quoted evidence base may be derived from flawed research.

It is well-recognised in the literature that more than 50% of patients with all grades of degenerative change affecting the joints and the spine including the most severe have relatively minimal symptoms and disability.

Clearly this mismatch between pathology and symptoms and disability must relate to the pronounced individual patient variability in pain processing and the interaction of psychosocial mechanisms. It is therefore imperative that these mechanisms are evaluated and managed from the start in order to then, if necessary, appropriately apply medical interventions including surgery.

If this biopsychosocial management approach were to be effectively applied it could be anticipated that a large proportion of current expensive medical treatment would no longer be required.

A misguided effort to manage chronic pain by liberalising opiate prescription has resulted in a massive additional public health problem in the form of large-scale abuse of medical opiates and demonstrably increased morbidity and overall lack of benefit.

Management of back pain by fusion or disc replacement surgery is another example of misguided non-evidence-based high-risk management resulting in additional health problems in more than 50% of treated patients. There are other examples of increasingly applied orthopaedic interventions (e.g. knee arthroscopy) which have limited or no evidence base and the capacity to aggravate underlying neural sensitivity syndromes.

The biomedical approach has demonstrably failed to manage this biopsychosocial condition yet it remains the central belief system in most medical specialties, medical schools and in the community as a whole.

Medical practice in the private sector is procedure- income driven and therefore there will be considerable resistance to alternative approaches that would likely diminish procedures .

The current treatment system is hugely wasteful of resources, ineffective and not infrequently harmful to patients.

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It is likely that embracing change from a biomedical system to a biopsychosocial self-management orientated system would result in significantly less health costs rather than more cost.

Funding and support for pain management services remains at a very low level.

Future planning and funding should focus on support for the biopsychosocial model of management and also education regarding early identification and evidence-based treatment of pain syndromes that relate predominantly to neural sensitisation or neuropathic pain mechanisms.

Early intervention is key and brief screening questionnaires such as the Orebro are well proven and available and reliably detect patients at risk of developing chronic pain related disability soon after the development of symptoms or injury.

For example in the work injured population, about 20% of workers screened by the Orebro for psychosocial risk factors soon after injury can be identified as being at risk of development of chronic pain disability and the recently completed (but currently unpublished) WISE RCT study in injured health workers in New South Wales has demonstrated that the development of chronic pain in this population can be reduced from 36% to 11% by an average of \$1000 worth of pain management CBT treatment and integrated rehabilitation within months of the injury. The very large majority of these injured workers then return to work within six months.

Further information regarding this study can be obtained from [REDACTED] at the Royal North Shore Hospital Sydney [REDACTED].

Injured workers receiving conventional medical management have about four times the risk of poor outcomes following orthopaedic surgery and in spite of around \$1 billion a year spent on the injured worker in Western Australia about 3000 workers per year develop permanently disabling chronic pain syndromes after soft tissue injuries and fail to return to work resulting in marked morbidity and cost both to them and their families and the community. This major public health disaster is, in theory, now largely preventable.

This study has already had a major impact on the management of injured health workers in New South Wales with insurers there converting to a WISE type intervention and CGU in Western Australia have recently decided that they will now operate a WISE type intervention for the injured workers that they insure and formally assess the outcomes compared to usual medical management.

The WISE study outcomes generate significant implications for the management of chronic pain disability in the health system as a whole.

If it is agreed that early intervention with CBT-based pain management education and treatment is key then opportunities to make this approach more widely available include:

1. Sufficient training of specialists, GPs and medical students regarding the biopsychosocial model of pain management and appropriate medication management (particularly for neurogenic pain syndromes) and use of screening questionnaires to identify at risk patients.
2. An early referral option to an internet-based CBT program. These are now available and of proven effectiveness (e.g. the Pain Course provided by Macquarie University New South Wales).
3. Identification of and support for allied health services offering evidence-based self-management orientated treatment approaches: physiotherapy, occupational therapy and psychology.
4. Chronic pain patients not responding adequately to early interventions as above should then be able to access review by a pain medicine specialist/multidisciplinary pain clinic within three months of referral with adequate

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funding available for placement on an appropriately intensive CBT pain program and to access evidence-based pain management interventions as appropriate.

5. Implanted neuromodulation therapy offers significant potential for improved management of neuropathic and neural sensitisation pain syndromes that have proved unresponsive to conservative management. Spinal cord stimulation implant therapy now has a strong level one evidence base for efficacy for neuropathic mechanism back and leg pain such as failed spinal surgery syndromes with demonstration of improved function and reduced analgesic medication requirement. Cost effectiveness has also been demonstrated with the initial high treatment costs being largely recovered within two years by reduced consumption of other treatment. Evidence of efficacy in upper body neuropathic pain syndromes is about to be published . The low risk and long-term safety of spinal cord stimulation treatment has been demonstrated over the last 40 years.

Minimally invasive injectable electrode wireless powered neuromodulation systems are now becoming available and offer the potential for much cheaper and earlier intervention in patients who are developing intractable neurogenic pain states .

Implanted neuromodulation treatment is currently not available in the public system in Western Australia and when previously funded was limited to about 20 systems a year. It should now be much better supported.

Outcome measurement is key to identifying that treatment input has been appropriate and adequately effective and will also drive ongoing improvement in services.

The eppoc (electronic pain patient outcomes collaboration) internet-based assessment and outcome measurement tool has been available for the last three years or so and is utilised in almost all major public pain clinics throughout Australia and an increasing number of private clinics (about 70 clinics in total at present). This data is processed by the University of Wollongong [REDACTED] and therefore represents an arms length measure of the effectiveness of pain management interventions and also the relative performance of individual clinics compared to the aggregate. However an adequate follow-up sample is yet to be captured in the large majority of clinics and more resources are required to achieve this.

Eppoc data needs to be tweaked so that functional outcomes related to specific treatment interventions can be identified and also return to work/study captured.

Pain specialists and pain clinics in the private sector providing interventions such as implanted neuromodulation should be obliged to participate with eppoc data gathering to demonstrate adequate outcomes from this relatively expensive therapy.

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