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Victoria Department of Health
Inquiry into women's pain

Via email: paininquiry@safercare.vic.gov.au

Written Submission for Victorian Government Inquiry into Women's Pain

Executive summary

- 2024 is an ideal year to grapple at a jurisdictional level with the issue of women's pain, since it is the Global Year Against Sex and Gender Disparities in Pain, as designated by the International Association for the Study of Pain (IASP)
- Persistent pain is almost twice as common in women as in men, and there are some types of pain which are exclusive to women, and those assigned female at birth.
- Reduction of gendered violence in society would have a significant effect on rates of persistent pain as trauma, sexual assault and childhood abuse are major risk factors for the development of persistent pain later in life.
- The current system of care in Victoria for pain treatment services shows significant regional disparities, with areas of relative adequacy of public sector service under significant strain and in need of support.
- The overriding priority recommendation from the faculty to the inquiry is to urge the development of a statewide strategic plan involving a survey of current services both public and private, followed by an ambitious plan to improve regional disparities and ensure a well-integrated basic level of service provided by properly trained and experienced specialist staff is available in all regions.
- The second most important recommendation is to support units which are currently either unable to provide fellowship training or on the verge of losing accreditation, to ensure a sustainable workforce and adequate service provision.
- The faculty is concerned about some of the details regarding individual units and their funding as well as provision of services such as implantable devices and inpatient care public system.
- PS15(PM) is our position statement which provides guidance as to the most effective and equitable clinical approach to resource allocation for those with persistent pelvic pain
- The faculty is actively involved in developing research and translation of new findings via APSRA

Introduction

The Faculty of Pain Medicine (faculty) of the Australian and New Zealand College of Anaesthetists (ANZCA) is responsible for the training and assessment of specialist pain medicine physicians, and for the standards of clinical practice in the specialty of pain medicine in New Zealand and Australia. The college's objective is to serve the community by fostering safety and high-quality patient care in anaesthesia, perioperative medicine and pain medicine. The faculty aims to promote the highest standards of patient care, including quality and safety.

2024 is an auspicious year for the Victorian government to conduct an inquiry into women's pain. The International Association for the study of pain (IASP) has designated 2024 as the global year against sex and gender disparities in pain. The campaign aims to:

- Highlight the importance of sex and gender disparities in pain and pain care.
- Communicate what we currently know about sex and gender disparities, highlighting the ways in which variation in pain occurs, as well as the biological, psychological and social-cultural reasons for this.
- Reflect on the challenges that a sex and gender approach highlights, in how we understand and manage pain, as well as approaches we should take to overcome these challenges.

There are a number of causes of the disparity of pain recognition, treatment and research between men and women including physiological differences (including sex-hormone linked physiololgical differences) social conditioning, cultural and economic issues, bias in research studies and implementation of research findings, lack of training and awareness of these issues by health care providers and indeed often by the general public.

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In general, any type of persistent pain is potentially a problem that affects women more, as for many important pain conditions such as migraine, pelvic pain, rheumatoid arthritis, chronic primary pain (formerly known as fibromyalgia syndrome), irritable bowel syndrome and persistent pain following surgery, there is a female to male preponderance of at least 2 to 1 in each case.

With regard to the terms of reference 1 and 2, the faculty will not make a formal submission, these being voices that should be heard directly from consumers. Our fellows dedicate their careers to assisting people with pain and are very familiar with the consumer point of view, but this document will be on the more systemic issues relevant to the Victorian health system.

3. Describe the impact of the current service delivery system on care for pain conditions
In Victoria this could be perhaps best described as a *'post code lottery'*. Victoria has a number of well established, nationally recognised clinical pain units, such as those at the Royal Melbourne Hospital, Barwon Health and St Vincent's Hospital but they are increasingly under threat due to poor retention of younger pain specialists in public positions and deprioritization of pain services post-pandemic. Outside of the geographic regions served by these established units, there are very large gaps in provision of even basic services across the state.

Historically, within the Victorian healthcare system the provision of best-practice pain care has fallen between the cracks of the primary care, sub-acute and ambulatory sector, and acute care sector. Acute hospitals have not seen provision of chronic pain management in a sub-acute setting as part of their remit. Rehabilitation or sub-acute facilities have tended to focus on allied health interventions with a lack of integration of medical care such as medication management, procedures or inpatient care. Acute pain management is usually done within anaesthetic departments in large hospitals if it is done at all. A small number of health services provide end-to-end care (or at least strive to provide it when resources permit). *The faculty contends that this is the ideal way for pain care to be provided.*

A patient in acute hospital with difficult-to-manage pain should ideally be seen as an outpatient soon after discharge, and followed up by the same team of clinicians as an outpatient who saw them as an inpatient if they have progressed to chronic pain status. This team of clinicians should have regular contact with areas of overlapping interests such as oncology, palliative care, orthopaedics, neurosurgery, drug and alcohol services and mental health services. This model of care is difficult to achieve in practise, and hence most services remained suboptimally integrated. This is at least partly due to the existing funding model whereby clinics are funded as "Health Independence Programmes" under ambulatory care models which typically utilize allied-health-only service models. Medical specialist care is marginalized and underemphasized as a result, despite it being the most powerful and potentially cost-effective contributor to reducing inpatient length of stay and preventing progression to chronicity. *Simply put, high-quality acute pain care in hospital reduces length of stay and potentially prevents a life-long issue of chronic pain for patients.*

According to the national outcomes data set maintained by the electronic persistent pain outcomes collaboration (ePOCC) Victorian chronic pain patients who attended a tertiary pain service with an established pain management programme tend to do relatively well compared to the binational benchmark figures. Unfortunately, fewer than 10% of patients referred for assessment by a pain service will make it this far through the process. Many do not meet admission criteria, or struggle to attend appointments due to coexistent mental health challenges or social demands. Missed appointments in the public sector have a devastating effect on the timeliness of care, and constitute a type of hidden waiting list within the service. Failure to attend to public hospital appointments (FTA rates) for public pain services are consistently in the order of 20% for this group of patients.

Many public pain services do not provide training for specialist pain medicine physicians via the faculty training programme, and for those that do, maintaining the required range of services and consultant supervision required by the faculty is a constant challenge. Units at the Western Health, Barwon Health, Monash Health and Peninsula Health are currently not able to provide core faculty training for this reason alone. The Alfred Hospital just meets the requirement, but is unable to increase its current appointment of specialists to allow for any redundancy, and will also lose core training accreditation if it reduces any lower.

To summarise the current situation, it's reasonable to say that no area of the state is well served by sustainable, well-integrated pain services. Even the most well-established units are struggling for resources and rationing services in one form or another. *The sustainability of pain medicine services in the public sector in Victoria is at a critical level and this requires urgent attention.*

Specifically with regard to the predominant pain conditions affecting women, there is a significant underinvestment in Women's Speciality pain services. The Royal Womens' Hospital has a very long waiting list for its pain clinic. Clinics specifically focused on endometriosis treatment provide little service to sufferers of pelvic pain with no diagnosis of endometriosis, and typically are focused on providing laparoscopic diagnosis and treatment without the full comprehensive approach that is needed to adequately manage persistent pain.

Abuse and trauma are major risk factors for chronic pain which disproportionately effect women. Pain clinics spend huge resources managing the fallout from unreported domestic violence, sexual assault and/or abuse often years after the events have occurred. In some cases, managing the safety of women from such gendered violence takes priority over treating their pain. Adequately addressing this enormous societal problem will have demonstrable beneficial effects for decades afterwards by reducing the number of women at risk of developing severe persistent pain, as well as reducing the number of children growing up in an atmosphere of family violence or other abuse. Specialist pain units often provide trauma-informed care to their patients and need support to develop more systematic and extensive links to support services for victims of gendered violence.

4. Identify opportunities to improve the care, treatment and services for pain conditions
The most urgent need for the Victorian health system is to develop a map of currently available services and use this as the basis for strategic planning. All other Australian states, and our cousins in New Zealand jurisdictions have developed strategic pain plans in accordance with the National Strategic Action Plan for Pain Management. A number of these have been disrupted by the pandemic but SA and NSW are clearly leading in this regard. Both have established government bodies within their health bureaucracies to oversee innovations in service models in areas of pain management and in the case of NSW specifically rural pain management services.

A strategic plan for the state needs to ensure that a full suite of pain services is accessible from anywhere in the state. Providing allied health management only, or medical treatments only is insufficient and likely to produce further fragmentation and duplication of services. Regional hubs need to be developed which can provide advanced pain therapies under the supervision of specialist pain medicine physicians, but a significant amount of early intervention management could be done in the community, or in a subacute setting by expert clinicians. The training and retention of these experts (medical, nursing, and allied health) is critical to the development of a long-term solution for Victorians with pain. Development and implementation of a strategic plan will ensure that resources are wisely stewarded in a way that maximises service provision in a cost-effective way.

A preferred model of care potentially based on work being done in South Australia which can integrate between community and hospital sectors should be developed. Potential augmentation of capacity by enlisting help from private services if required in some areas should be an early priority of the implementation of a strategic plan. Private sector pain units can provide expert clinician input to case management, procedures and pain programmes in liaison with public providers under appropriate arrangements to spare the need to build services de novo.

A significant number of Victorians with persistent pain have developed the condition from compensable causes or injuries. The faculty is currently part of a working group with high level representatives from WorkSafe Victoria and TAC to examine some of the barrier issues with regard to pain management full compensable patients, but this work relies on significant pro bono input from the clinicians involved. It is mainly concerned with high-cost items such as inpatient treatment for implantable therapies but there is significant scope to widen the brief of this group into a more formal project to include pain treatment more generally as part of an ongoing commitment to improving the performance of insurers. Managers of compensable injuries are highly aware of the costs of providing care for persistent pain patients, and there is not enough being done to streamline access to services or adequately support provision of best-practice care for injured Victorians.

Training of healthcare professionals is another area where national standards will lift the standard of care. The faculty has been tasked with undertaking the development of national standards for health practitioner education in pain management and this will be complete next year.

Training positions in pain medicine need to be urgently created in the public sector so that the delivery of pain services will be led by professionals dedicated to pain care. Units whose ability to train is marginal (either just under or just over the minimum required resources for the faculty training program) need to be supported to ensure they can maintain accreditation.

Specifically regarding the relationship of persistent pelvic pain to endometriosis, attention is drawn to the faculty's professional document on this topic. PS15 (PM) is a faculty position statement which calls attention to the fact that the traditional view of endometriosis as a leading cause of persistent pelvic pain is no longer tenable. The scientific evidence and the implications surrounding this position are detailed in length in the position statement, which is attached as appendix 1. *The faculty strongly advocates that this point of view is taken into consideration when allocating funds intended to improve the lives of women with pelvic pain, whether endometriosis lesions are present or not.*

5. Consider appropriate models of care, service delivery frameworks, workforce skill mix, and other areas requiring change.
The faculty strongly advocates for specialist led teams at a regional and above level. Research knowledge and practice of clinical pain care has exploded in complexity in the last 25 years. It is no longer appropriate to try to manage some of these most challenging of complex patients in unimodal, primary care settings such as community health centres or private allied health clinics. Credentialling of allied health professionals as specialists in pain care is available for physiotherapists, and osteopaths but not other professionals. Poorly delivered or less than comprehensive assessments and treatments undermine the faith of patients in their ability to recover from the onset of chronic pain, a scenario that faculty fellows encounter constantly. Development of an achievable but ambitious long-term strategic plan should include this fundamental goal. Allied health-led teams in primary care may be better than no care at all, but the faculty is working with the MBS to try to facilitate funding for community-based specialist care and Medicare funding of primary care, community-based pain teams. Lack of a systematic plan will simply entrench the current postcode lottery whereby some regions are well-served and others completely miss out.

Implantable devices such as intrathecal drug delivery systems or neurostimulation devices were removed from funding in the Victorian health system without consultation with the sector in 2018. This has had a disastrous effect on the ability of Victorians to equitably obtain access to specialised pain therapies. In contrast to other states, particularly Queensland and South Australia, where devices are integrated within the state budget to be provided in centres of excellence, Victorian public patients are denied the opportunity for these devices altogether. The out-of-pocket cost for a trial and implantation of a spinal cord stimulation device is in the order of $50 to 80,000 and while Victorians with private insurance can access these specialised treatments, they are completely unavailable within the public system. They may be high-cost items, at least initially, but the ongoing cost of poorly treated pain to the Victorian health system and the Victorian economy in general is probably even higher, given the lost productivity of chronic pain sufferers, their higher rate of hospital admissions and longer average length of stay compared to pain-free individuals and the relative success rate of these devices in carefully chosen and supported individuals.

Support for training positions in pain medicine in the private sector needs to be explored. The supply of Specialist Pain Medicine Physicians is heavily constrained by the lack of public training units as outlined earlier. Development of some well-planned Public/Private partnership units should be explored as a potential alternative to expanding the major metropolitan hospital stranglehold on training positions. This is potentially another means by which resources can be redeployed to regional areas without dropping standards in either training or service provision.

6. Translate research and evidence-based interventions that address unwarranted sex and gender variations and improve the equity of outcomes relating to the access and efficacy of pain management
The faculty has helped to drive the creation of the Australian Pain Solutions Research Alliance (APSRA) which is an umbrella organisation whose purpose is to bring consumers, funders, clinicians and scientists together with the unified program of research priorities and a community or network of like-minded colleagues dedicated

to the development of research and its immediate impact for translation into practice. APSRA is still in its foundation phase, and the inaugural chair is Prof Mark Hutchinson from South Australia. Prof Hutchinson is an internationally recognised research scientist, and the board and advisory Council of the alliance contains many of the sector's most impressive academics and young researchers. The faculty has a board representative whose role includes driving the translation aspect of the alliance's mission.

The faculty is highly supportive of translation efforts for well-evidenced interventions that can be implemented quickly and reliably by faculty fellows in their units with appropriate clinical surveillance to monitor quality and outcomes which allows responsible innovation.

Conclusion
The faculty welcomes the opportunity to make a submission to this inquiry. As the experts in assessment and management of persistent pain and acute pain conditions, our fellows are a valuable resource to contribute to the development of effective policy in this area. Victoria is late in starting to formulate strategic planning for persistent pain services compared to other jurisdictions that the faculty works across. We look forward to assisting the Department to understand the magnitude and implications of this problem as it applies to the frontline clinicians and those who may serve.

Should you wish clarification of any of these comments, please do not hesitate to contact A/Prof Vagg or me at fpm@anzca.edu.au

Yours sincerely,

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