

## How badly do we want to solve this \$32bn dollar persistent pain problem?

Written by The Conversation

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This week is [National Pain Week](#) so it's only fitting that I should climb onto the soapbox again in support of people with persistent pain, their employers, workmates, friends, and families. The economic burden of persistent pain in our country is enormous, and the arguments in favour of a co-ordinated national response are compelling. The lack of such a political and economic imperative puzzles me. If you don't believe me, perhaps [this](#) will convince you.

The Australian Institute of Health and Welfare (AIHW) is the government body charged with keeping track of the nationwide statistics in health. The AIHW report *Australia's health 2014* nominates musculoskeletal conditions as contributing 15% of the total disease burden in Australia. By comparison, cancer came in at 16% and mental health at 13%. When you add in the impact of injuries and trauma, persistent pain becomes the biggest definable contributor to national lack of health and ability.

Just think about those numbers for a minute. Think of all the fundraising and public awareness campaigning that is done for cancer research, mental health, heart disease and a host of far less common conditions. Where are the research institutes for chronic pain? Where are the telethons? Where are the themed sporting events?

If you consider that four out of the nine [National Health Priority Areas](#) are big contributors to the burden of persistent pain, it seems unthinkable that a national response by the states and the Commonwealth has been overlooked to date. As a taxpayer looking for value from the health system, I demand it.

The effects of lack of coordination can be seen everywhere. Here are a few that particularly grind my gears:

### Lack of proper PBS coverage for persistent pain

Neuropathic pain, that is pain which arises from a disorder of the [somatosensory system](#) as opposed to direct tissue damage, occurs in somewhere between 5 and 20% of the population at some time in their life. Common types of neuropathic pain include painful diabetic nerve damage, pain following shingles, sciatica, and pain following a stroke, MS or spinal-cord injuries. Neuropathic pain is also relatively common in cancer survivors due either to the

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disease or a complication of some types of chemotherapy.

If you look at the [PBS listing of drugs](#) you will find neuropathic pain mentioned only once out of the hundreds of drugs approved for use. Clearly there is more than one drug which works for neuropathic pain, but the majority of prescribing which I do for neuropathic pain is off-label, and therefore strictly speaking outside the PBS guidelines. Another consequence of this limited recognition of neuropathic pain is that strong opioid drugs, which are now considered a poor second-line treatment by international standards are the only thing an average GP would consider prescribing based on what is available with subsidies on the PBS.

The reason this has arisen is because the PBS makes diagnosis based approvals, instead of mechanism based approvals. This makes it extremely difficult in terms of expense and market limitation for companies to get treatments on to the schedule.

The situation in New Zealand is even worse. Many of my colleagues in pain medicine in New Zealand are simply not allowed to prescribe internationally recognised first line neuropathic pain drugs because they cannot be sold in New Zealand at all for a similar reason.

## Underinvestment in pain management by the states

Within the public health system, Departments of Pain Medicine are usually aligned operationally with the Department of Anaesthesia for their hospital. Anaesthesia is clearly an acute hospital specialty and is well established as such. Pain medicine on the other hand is a subacute specialty with an interdisciplinary foundation and sits awkwardly in the acute hospital setting. I have been told on numerous occasions by management that elective admissions for pain treatment such as procedures or inpatient admissions for drug manipulations are a low priority for acute hospitals. Every Pain Medicine Unit in the country faces a similar problem.

With the looming crunch in health funding that the states are now facing, this situation is very unlikely to change. It is likely to get worse. This pushes back the economic consequences further into the future and consigns thousands of future chronic pain patients to a situation where they will never get appropriate care which could save them from a life time of disability and poverty.

## Lack of development in the pain management workforce

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Amazingly, there is still only one university in the country which offers postgraduate training to health professionals at [Masters level](#) in pain medicine. It calls me to think of places like the University of Tasmania offering worthless courses like [this one](#)

when there is a national health care crisis in pain management that they could be part of solving. The health professions need to follow the lead of the medical profession in establishing career paths for professionals wanting to devote their careers to this area.

Nurses have a pathway towards subspecialty qualifications in pain management, but there are too few undertaking it. I believe that the Clinical Nurse Consultant role forms one of the most potentially valuable areas for further development of community services. Physiotherapists would be ideally placed to lead the community care of persistent pain patients, but they have only recently managed to establish a [network of interested professionals](#) to support ongoing education and raise professionalism in this area. Australia also has a handful of world-class physiotherapy academics contributing to important research in pain. Psychologists and Occupational Therapists are two other critically important professions which are lagging in developing special interest groups to implement the existing evidence-based treatments in their fields, let alone broaden the knowledge base with research. Given the social disadvantage experienced by chronic pain sufferers, and the emphasis in current practice on the social context of chronic pain patients in their care, any recognition of subspecialty interest and training for Social Workers would be a welcome development.

None of these problems is insurmountable given intelligent use of resources and determination of political and bureaucratic types to see the job through. We already have a [national strategy](#) sitting on the shelf ready to be implemented. We have had it for the last five years. Australia is already a world leader in many respects in the field of pain management, but admittedly, it's a low bar at the moment. There would be few areas of public health where a generous budget applied with intent and direction would yield such massive social and economic returns.

So, citizens and taxpayers, and future persistent pain patients, how badly do you want this to happen?

**Read more** <http://theconversation.com/how-badly-do-we-want-to-solve-this-32bn-dollar-persistent-pain-problem-44953>