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AMA submission to the Australian Commission on Safety and Quality in Health Care – National Opioid Analgesic Stewardship Program

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Executive Summary

The AMA supports the development of a National Opioids Analgesic Stewardship Program (referred to as the Program hereafter). However, there are several system-wide issues that must be addressed for the Program to meet its full potential. This includes increasing hospital funding, communication between care providers, and the accessibility and affordability of non-opioid services in the community. Education interventions must be carefully thought out and developed under consultation with the relevant medical colleges and the AMA. The Program must ensure that clinical independence is maintained to prevent barriers to opioid prescribing for patients who have a legitimate clinical need.

Introduction

The AMA has been a supporter of and contributor to national opioid reform for several years. The AMA has contributed to the Therapeutic Goods Administration's (TGA) Opioids Regulatory Advisory Group and the Opioids Regulatory Communications Committee, as well as providing submissions to the various consultations such as the TGA consultation on upscheduling codeine to prescription only.

The AMA supports the development of a Program, with accompanying clinical care standards and guidance on education for health professionals. As the discussion paper outlines, there are several resources available to doctors to assist them in their opioid prescribing. However, a Framework on the national level is so far lacking.

In the interests of patient safety, the AMA supports measures to control access to certain medicines that are prone to addiction and misuse. However, prescribing regulations and measures should not pose a barrier to medical practitioners treating their patients or impose an administrative burden without evidence that they are effective and necessary. Alternative approaches such as audit mechanisms should be explored before additional regulation is imposed on prescribers.

The ACSQHC must be careful in the development of the Program to ensure that the stigma of opioid users is not perpetuated, that patients are treated with dignity and respect through recognising that opioid addiction is a health issue. The Program must recognise that many patients have a legitimate clinical need for opioid analgesics, and that patients have a human right to receive pain relief.

In addition to developing a stewardship Program, there are several system-wide issues that must be addressed to reduce the inappropriate use of opioids. Without the changes below, the program will not be as effective as it could be.

Hospitals are overrun and under-resourced

Page 18 of the consultation paper identifies several issues that impact on an emergency department (ED) clinician treating a patient with acute pain, including time pressures, patient pressures to relieve pain, and a lack of information about the patient. These issues are symptoms of an overstretched public hospital system.

The AMA's *Public hospital report card*[1] analyses the pressures that Australia's public hospitals face and shows a decline in public hospital performance since 2013-14. For example, in 2018-19, more than three million emergency patients required urgent care, but only 63 per cent were treated on time. The number of emergency patients who require a subsequent admission after their emergency treatment rose between 2013-14 and 2018-19 at nearly twice the rate of overall emergency presentations, and 3.5 times the rate of population growth.

Any change in patient care requires resourcing. This will include an increase in staff to allow for education and training, and the expected impact on patient flow. Even if clinicians are spending an additional 2-5 minutes on each patient in the ED, this will affect the number of patients clinicians can see, particularly in the busier hospitals that are already understaffed and under time pressures. Further, AMA members report that prescribing practices in the ED may not change significantly due to these time pressures and the fact that ED patients typically have a significant clinical need for analgesia.

Public hospital elective surgery is also not meeting the demands of Australian patients. In 2018-19 more patients were added to elective surgery waiting lists than were admitted for their elective surgeries. The national median waiting time for elective surgery was the worst performance since 2001-02. In 2018-19, only two states improved the proportion of Category 2 elective surgery patients admitted within 90 days. The performance of all other jurisdictions was either no better than the year before, or worse[2].

The AMA anticipates that the Program will assist in reducing inappropriate prescribing in hospitals. However, best-practice, quality and timely care cannot be achieved without public hospital funding properly reflecting the cost of providing these outcomes.

[1] Australian Medical Association (2020) *AMA Public Hospital Report Card.*
[2] Ibid.

Demand on public hospitals will only continue to grow over time with an ageing population and an increase in chronic, complex medical conditions requiring emergency and surgical care. Patients with pain-related medical conditions will not receive the best possible care under such pressures under the current funding model.

My Health Record and communication between care providers

My Health Record is intended to provide treating clinicians with essential clinical information that is otherwise unavailable at the time the patient presents in an ED. However, the patient's My Health Record will only be as good as the information that has been uploaded by other treating healthcare providers. Wherever the medicines information uploaded to the patient's My Health Record is complete, it should make a positive contribution to best practice opioid prescriptions in hospitals.

However, reliance of information in a patient's My Health Record will not be a silver bullet to achieving best practice opioid prescribing because the Record is patient controlled. The patient can request a prescriber and a pharmacist that dispenses the medicine to not upload the script details to their My Health Record, or a patient can effectively remove a dispensed medicine from the My Health Record. Only the healthcare provider that uploaded that clinical document will be able to see that the document has been removed. The patient-controlled nature of the My Health Record is one of the consumer facing features of the Record.

Therefore, adequate communication with the patient's usual general practitioner (GP) and a comprehensive discharge summary is crucial to ensuring the patient does not have issues with their hospital-prescribed opioid medication. The AMA's position statement on *General Practice/Hospitals Transfer of Care Arrangements* outlines the requirements for appropriate and effective transfer of care[3].

Real time prescription monitoring

The AMA supports the introduction and funding by governments of electronic systems, such as real time prescription monitoring (RTPM), to collect and report real-time prescribing and dispensing data relating to these medicines as an effective means of addressing problems of forgery, dependency, misuse, abuse and prescription shopping.

While several States and Territories have produced their own RTPM systems, there needs to be as much national consistency as possible for it to work. Any system must be integrated with a national data base to ensure people do not avoid detection by crossing a State or Territory border. RTPM systems require seamless interoperability with clinical software used in hospitals and practices.

The AMA understands that the Federal Department of Health has developed a National Data Exchange (NDE) that State and Territory RTPMs can feed into[4], however it appears that progress

[3] Australian Medical Association (2018) *General Practice/Hospitals transfer of care arrangements*.
[4] Department of Health (2021) *National Real Time Prescription Monitoring.*

is slow. For example, while the NDE was released in December 2018, NSW only recently consulted on amendments to legislation to enable RTPM implementation[5].

Improve access to non-opioid services in the community

Long term pain management treatments are best suited to be developed in General Practice and de-prescribing or tapering regimes should be done in collaboration with the patient's usual GP. De-prescribing practice and education should be incentivised through consideration of GP funding schemes. Deprescribing and associated minimisation of health risks may contribute to health savings, however GPs must be supported financially to do this.

Deprescribing also requires the right settings, resources and aids. Guidelines around pain management encourage the use of non-opioid therapies across a range of disciplines such as alcohol and drug services, pain specialists, palliative care, physiotherapy, psychiatry, psychology, and dietetics. These strategies are important for acute and chronic patients who have received care in the community and in hospital. However, at present, many of these services are not accessible to patients. For example, most pain management services are located in major capital cities, leaving a significant gap in rural and remote areas. Up to 80 per cent of patients with chronic pain are not receiving treatment to improve their quality of life[6]. Some regional areas prescribe opioids at ten times the rate of other areas[7].

The introduction of permanent telehealth items linking rural, regional, and remote patients to their usual GP and non-GP specialists would assist in regular monitoring of pain patients and increase accessibility. The AMA believes that telehealth should be complementary to face to face consultations, not a replacement.

Further, pain management for residents of residential aged care facilities (RACFs) is currently inadequate due a lack of focus and investment in high quality clinical care in RACFs, causing a significant amount of avoidable hospital admissions[8,9]. More than 60 per cent of dementia patients transferred to a Severe Behaviour Response Team have not had their pain diagnosed or identified, highlighting the need for better pain assessment in aged care and hospitals[10]. There is a particular need for education around recognising pain in patients who may be non-verbal.

In addition to inaccessibility, some of these services are unaffordable due to the chronic underfunding and indexation freeze of Medicare items and the need for private health insurance to subsidise particular services, with premiums becoming increasingly unaffordable for many Australians[11].

[5] NSW Government (2021) *Consultation: Real Time Prescription Monitoring (RTPM) – amendments to the Poisons and Therapeutic Goods Regulation 2008.*
[6] Department of Health(2019) *National strategic action plan for pain management.*
[7] Ibid.
[8] Australian Medical Association (2021) *Putting health care back into aged care.*
[9] Australian Medical Association (2019) *AMA submission to the Royal Commission into aged care quality and safety*
[10] Department of Health(2019) *National strategic action plan for pain management.*
[11] Australian Medical Association (2020) *AMA Private Health Insurance Report Card 2020.*

To reduce the inappropriate prescribing of opioids in hospitals and patient reliance on opioids, the Government must ensure non-opioid services are available to patients after they are discharged. This includes investing in accessibility and affordability of non-opioid services and preventative care, coordinated and led by the patient's usual GP.

Education interventions with health professionals to improve prescribing competency for the use of opioid analgesics

The AMA supports developing education interventions for health professionals around best practice prescribing of opioid analgesics.

Education needs to be available to all potential opioid prescribers at all levels of training and also tailored to each group. Generic, one-size fits all packages are unlikely to have high face-value or any acceptability. Education interventions could be co-designed between multidisciplinary teams including GPs, pain specialists (acute and chronic), pain nurses, patients, and pharmacists.

Education programs should be adequately funded and incentivised through Continuing Professional Development points.

Interventions must be evidence-based and well thought through in consultation with the relevant peak bodies such as medical colleges and the AMA. For example, the Department of Health set up a randomised controlled trial to see whether GPs with high rates of opioid prescribing would reduce their prescribing rates after they received a letter from the Department[12]. While this initiative saw a reduction in opioid prescribing, the process could have been a lot better. Nudge letters like these can have unintended consequences if not communicated appropriately. The initial letters caused significant anxiety for recipients. GPs were intimidated by the letter and feared they would be sanctioned or their prescribing rights revoked. The study was not able to distinguish those GPs who have clinically appropriate reasons for their high prescribing rates. For example, those who have a high number of palliative care patients. The report stated that GPs who received the letter had a large proportion of patients receiving palliative care. The then Chief Medical Officer wrote a public letter of apology[13] to GPs who were involved in the study.

Done well, the provision of data to medical practitioners can provide an opportunity for them to review their prescribing of opioids in light of the latest evidence, and in comparison with their peers, to ensure it is clinically appropriate. Future campaigns like this need to be focused on providing information for practitioners in a non-threatening way that is educative in nature, so that best practice care can be provided.

The Program should also include audit and quality oversight parameters to assess the impacts of educational interventions for each relevant clinician group to ensure they significantly optimise prescribing and decrease opioid addiction and its consequences.

[12] Department of Health (2021) *Opioid prescribing practices project.*
[13] Murphy, B (2019) *Australia's Chief Medical Officer responds to GP questions over opioid warning letter.* News GP

Program governance

The ACSQHC should consider including a governance framework for the Program's design. This should involve several disciplines to ensure the framework represents the various fields in which pain management and opioid prescribing occurs. This includes representatives from the following professions:

- General practitioner
- Emergency department physician
- Surgeon
- Rural medical practitioner
- Pain specialist (chronic and acute)
- Medical school (or junior doctor)
- Pharmacist
- Registered nurse (community and hospital)

Research

Opioids are effective analgesia for acute pain and in some circumstances non-opioid pharmaceutical analgesics are not adequate pain relief for patients in hospitals, particularly the ED. A stewardship program must also recognise that there is a need for supporting further research into non-opioid analgesics, and non-pharmaceutical pain management.

Conclusion

The AMA supports the development of a national opioid analgesic stewardship program. The discussion paper outlines several important research-based initiatives that will be useful in developing clinical guidelines and education for health professionals under the program. However, the AMA believes that the aims of the Program will not be fully met unless a range of system-wide issues are addressed, including hospital funding and the accessibility and affordability of non-opioid services available in the community. Development of educational interventions should be done in consultation with the relevant medical colleges and the AMA to ensure interventions are educational in nature and not threatening to the prescriber. The program must ensure that clinical independence is maintained to prevent barriers to opioid prescribing for patients who have a legitimate clinical need.

The AMA looks forward to working with the ACSQHC throughout the development of the program.

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