AUSTRALIAN MEDICAL
ASSOCIATION
ABN 37 008 426 793

T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au

42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

# AMA submission to the Medical Services Advisory Committee – 1698 Chronic Pain MedsCheck Trial

**commentsMSAC@health.gov.au**
**Cc: pharmacy.trial.program@health.gov.au**

***Describe your/your organisation's experience with the medical condition (chronic pain), the proposed intervention and the service described in the Consultation Summary.***

The AMA is the peak body representing Australia's medical professionals. Chronic pain is not a single morbidity that can be treated in isolation of the causes (injury, cancer, psychological issue) or the effects of a person's pain (dependence, disability). GPs see patients with chronic pain on a daily basis, managing this pain through existing MBS items, in collaboration with non-GP specialist, allied health professionals or with community pain clinics. Non-GP specialists also manage chronic pain in their patients. The Faculty of Pain Medicine is the body responsible for training, education and standards for Pain Medicine in Australia and New Zealand. It includes fellows of The Royal Australasian College of Surgeons (RACS), The Australian and New Zealand College of Anaesthetists (ANZCA), the Royal Australasian College of Physicians (RACP), and the Royal Australian and New Zealand College of Psychiatrists (RANZCP). Chronic pain is managed across the profession.

AMA members did not participate in the study and we have not received reports from members who may have received referrals from participating pharmacists.

***What do you see as the benefit(s) of the proposed service, in particular, for the person involved and/or their family and carers?***

The AMA sees limited benefit from the service. As the population used in the study were not receiving any pain medicine services or interventions at the start point of the study, it is not surprising that some positive outcomes were identified in participants. Generally in trials of health interventions, a new intervention is tested against a "usual care" arm because any intervention is better than nothing. Without at least one proper control arm of usual care, there can be no genuine outcome determined from this study.

Chronic pain management is best managed by multidisciplinary or interdisciplinary teams. Pharmacists are a vital part of these teams, particularly if the intention is to taper pain medicine usage, but this work cannot be performed in a silo where the other factors driving chronic pain are not addressed. This report mentions that some participants are referred to the GP or allied

health professional, yet there is no measurement of how many participants were referred, nor the impacts on outcomes of the referral. This is a significant oversight in the evaluation of the trial and speaks to the generally poor study design.

***What do you see as the disadvantage(s) of the proposed service, in particular, for the person involved and/or their family and carers?***

The major disadvantage of this proposed service is the fragmentation of care. The AMA is fully supportive of Medication Management Reviews because they use the expertise of accredited pharmacists working in collaboration with GPs to manage a person's medications. In the context of pain medicines, even over the counter options, it is essential that a person's usual GP is involved, and in many instances other specialists and allied health professionals should be involved as well.

The AMA is increasingly concerned with proposals that will fragment care as health system pressures grow. Poorly coordinated patient care within the health system and inadequate links between health and social services results in poorer health outcomes and increased health care costs. Ill-considered cost reduction strategies, like task substitution of non-medical health professionals for GP-led patient care, are increasingly proposed as a solution to these pressures.

When we have successful models of community pain management operating around the country as well as effective medication management reviews in place, we would prefer to see Government increasing funding and support for these models, and in particular for general practice instead of seeking ways to produce lower-quality care solutions that are not necessarily cheaper in the long term. For example, the AMA believes that investment into general practice pharmacists is a more valuable method of providing holistic care while improving engagement between pharmacists and GPs.

***What other services do you believe need to be delivered before or after this intervention, eg. General Practitioner, Pathology etc?***

Every participant in this trial should have been referred to their usual GP. Part of the initial consult should have been to determine if they were also receiving care from a non-GP specialist for other associated issues.

***What other training or education do you believe would be useful for health practitioners delivering this intervention?***

Pain medicine is a two year post-specialty qualification for doctors, including GPs, psychiatrists, rehabilitation specialists, physicians, anaesthetists and surgeons. The suggestion that three to four hours of online training could prepare a pharmacist to provide pain management services is alarming. This is demonstrated in the report where participating pharmacists rated 'developing an action plan' as 'harder to perform'. This is the core of what the study should have been about.

Pharmacists were reported that the mini-ePPOC tool was easy, yet this too was noted as "not appropriate for use within specialist pain management services, and services should continue to

use the full version" by the clinical and management advisory committee of the Electronic Persistent Pain Outcomes Collaboration, who designed and continue to monitor the full tool and the mini version.[1]

***Do you agree or disagree with the proposed population(s) for the proposed service as specified in the Consultation Summary?***

The AMA does not support the program. This trial is poorly designed and executed. The trial had two arms which we very similar that were only compared against each other. It ran for only three months, which the report notes was not long enough to determine effectives. It was little more than a pilot study which could be used as the basis for a larger study that should use actual comparisons with existing services. In this instance, it did not compare itself against the numerous existing pain management options available to patients, either through their GPs, community pain clinics, or specialist pain management services. As participants in the study were starting from a point of no pain management beyond medications and there is no comparison to any other services, there is no way to determine that this service improved the outcomes of participants when compared to existing services.

***Do you agree or disagree with the comparator(s) to the proposed service as specified in the Consultation Summary?***

As explained in other answers, this is far from satisfactory when designing and evaluating a trial.

***Do you agree or disagree with the clinical claim made for the proposed service as specified in the Consultation Summary?***

The AMA is fully supportive of improving pain management and decreasing dependence on pain medications in Australia. We note that as of 27 May 2022, there are 257 results in the Australian New Zealand Clinical Trials Registry for the search term 'pain management'. There are many studies of various sizes at different stages that are intended to address these issues. There are valuable studies with validated tools seeking to measure interventions which would be properly evaluated against existing treatments and include at least a literature review that cannot receive funding due to high competition. This trial, along with the others funded under the 6CPA, lack appropriate academic rigour.

Australia also already has some very successful pain management models, largely multidisciplinary, which simply require more funding and support.

The frustrating reality is that this trial was funded is a result of agreements made as part of the 6CPA by the Pharmacy Guild to increase business for their members - community pharmacies (businesses). This represents a direct conflict of interest because Guild members will directly benefit from government funding and an increase in profits by expanding the program. Ideally, research should be independent.

[1] Electronic Persistent Pain Outcomes Collaboration (EPPOC) Clinical and Management Advisory Committee (2020) *Key Decisions - Meeting*

***Do you agree with the proposed service fee described at page 16 in the CPMC Consultation Summary?***

As noted earlier, the trial was not appropriately designed with comparison arms to usual care. The trial mentions referrals to GPs and allied health services, yet does not include these in analysis. It is not possible to determine from the report how it compares to existing services, or the role that they played in any success for participants.

***Do you have any additional comments on the proposed intervention and/or medical condition (disease) relating to the proposed service?***

The AMA opposes the Chronic Pain MedsCheck application. The trial provides insufficient evidence alone to justify support for a program that fragments care of often vulnerable people and has not demonstrated in anyway that it provides a service for a population that is missing out on essential care.

Medical services are typically backed by several high quality studies before they even considered through the MSAC process  In contrast, the CPMC is only one trial that does not research the effectiveness or cost-effectives in the context of wider public health or other more readily available and evidence-based medical services.

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