2024-25 Pre-Budget Submission

Australian Self-Care Alliance Ltd

www.selfcarealliance.org.au

25 January 2024

Executive Summary

"Self-care is a key component of universal health care." Minister for Health and Aged Care, the Hon Mark Butler MP, in his letter to the Australian Self-Care Alliance, dated 4 October 2023.

The Australian Self-Care Alliance (the Alliance) is a collaboration of healthcare consumers, health promotion charities, policy experts and industry partners. Our aim is to promote the adoption and implementation of self-care for health as a fundamental component of Australia's physical and mental healthcare policy and practice.

Consistent with what former Whitlam Government Health Minister, and architect of the Community Health Program, the Hon Doug Everingham, described as "community health care rather than sick care"; self-care for health is an evidence-based, complementary, and cost-effective component of health policy and practice that, empowers and supports individuals and communities in the management of their health; enhances preventive health action; fosters a more health resilient population; and helps ensure the sustainability Australia's healthcare system and services.

If properly supported, self-care can be a game changer for health with research showing:

- empowered health consumers, who take greater ownership of their journey, achieve better health outcomes[1],
- individuals who lack the skills to undertake self-care effectively incur higher health service costs[2], and
- economic modelling[3] indicates that greater self-care has the potential to save Australia's healthcare system between $1,300-$7,515 per hospital patient, per year, and significantly lower hospital readmission rates[4].

Evidence suggests that up to 80% of heart disease, stroke, and type 2 diabetes, and over a third of cancers, could be prevented through evidence-based self-care – eliminating or reducing exposure to the risk factors of tobacco use, unhealthy diet, physical inactivity, and excessive alcohol consumption[5].

For Australia, this means that an estimated 29,300 lives could have been saved between 2018 and 2025 if self-care was embedded in health care to enhance preventive action and chronic disease[6].

As Minister Butler stated in his letter to the Alliance, dated 14 March 2023, "The Australian Government recognises the importance of empowering individuals and enhancing self-care capabilities to improve health and wellbeing outcomes, address the burden of disease and promote health equity".

---

[1] PricewaterhouseCoopers: The future of health in Australia - https://www.pwc.com.au/health/health-matters/the-future-of-health-in-australia.html

[2] - Hibbard, J.H., J. Greene, and V. Overton, Patients with Lower Activation Associated with Higher Costs; Delivery Systems Should Know Their Patients' 'Scores'. Health Affairs, 2013. 32(2): p. 216-222. - Brady, T.J., L. Murphy, B.J. O'Colmain, D. Beauchesne, B. Daniels, M. Greenberg, M. House, and D. Chervin, A Meta-Analysis of Health Status, Health Behaviors, and Health Care Utilization Outcomes of the Chronic Disease Self-Management Program. Prev Chronic Dis, 2013. 10: p. 120112

[3] Mitchell Institute for Education and Health Policy "Self-care and health: a national blueprint" - https://www.vu.edu.au/sites/default/files/mitchellinstitute-self-care-for-health-a-national-policy-blueprint.pdf

[4] Roughead, L., S. Semple, and E. Rosenfeld, Literature Review: Medication Safety in Australia. Sydney: Australian Commission on Safety and Quality in Health Care, 2013.

[5] World Health Organization, Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020.

[6] World Health Organization. *Noncommunicable Diseases (Ncd) Country Profiles 2018: Australia* 2018 - https://www.who.int/nmh/countries/2018/aus_en.pdf?ua=1

Australia's current healthcare structures, culture and professional development do not adequately encourage, incentivise or support health professionals and services to engage or empower individuals in the proactive management of their health, impeding greater self-care, and a healthier future for all Australians.

Greater self-care and empowerment in health requires a health and care environment that provides individuals with health information, resources, skills and support they needed to improve their health and well-being, and be an informed advocate for, and active participant in their own health.

Modest but designated self-care investment is required to enhance Australia's self-care capabilities in two (2) complementary perspectives: one focused on the capacity of individuals to self-care, and another focused on how self-care is supported through policy and within the health system.

The investment in person-centred self-care is urgently required to address Australia's contemporary health needs - non-acute and preventable illnesses, chronic condition management, mental health services, and specialist care for acute illness and complex, chronic health conditions – and ensure the long-term sustainability, and affordability of Australia's healthcare system and services.

The Alliance commends the Albanese Government's decision to build on the legacy and ethos of the Whitlam Government's Community Health Program, "a comprehensive model of health that looked beyond the narrow medical reasons for episodes of illness, towards a greater understanding of the social determinants of health"[7]; and incorporate its value lessons into their ongoing Strengthening Medicare reforms.

Empowering and supporting individuals to have greater involvement in, and ownership of their physical and mental health management, and outcomes should be a defining characteristic of Australia's health and care systems, services, and supports.

Through targeted investment in the proposed self-care initiatives, policymakers can begin to lay the groundwork for this vision and help all Australians to become an informed advocate for, and active participant in their own health.

As stated in the Mitchell Institute's report, *Self-care for health: A national policy blueprint*[8]:

> *"Governments and policymakers are largely responsible for creating environments which either inhibit or enable self-care, and play a major role in the development of self-care capabilities at the population level.*
>
> *Health professionals and service providers also play an essential role in supporting and facilitating self-care by healthcare consumers. Other key self-care stakeholders include families, communities and health and industry organisations."*

[7] The Hon Mark Butler, speech to the Whitlam Institute, at https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/minister-for-health-and-aged-care-speech-3-november-2023

[8] Mitchell Institute for Education and Health Policy "Self-care and health: a national blueprint" - https://www.vu.edu.au/sites/default/files/mitchell-institute-self-care-for-health-a-national-policy-blueprint.pdf

Australian Self-Care Alliance's Budget Recommendations

1. **Invest $6 million over five years to develop and implement a digital health information accreditation scheme and a library of accredited digital health information apps.**
   The new Digital Health Blueprint 2023–2033 and action plan highlights the need for digital health tools to be trusted. A digital health information accreditation scheme and a curated library of accredited digital health information apps will deliver on this objective.

2. **Fund the national rollout of the Asthma Australia's AirSmart program.**
   Modelled on the highly respected and successful SunSmart UV Index program, AirSmart fills the need for community education and guidance around air quality which was revealed by the 2019–2020 bushfire smoke crisis.

3. **Allocate funding to enhance Chronic Disease Management services available for people living with chronic pain.**
   As outlined in Painaustralia's New Policy Proposal, enhancing the scope and coverage of the chronic disease management framework and its services for Australians living with chronic pain would double access to multidisciplinary care for 3.4 million Australians and their families; resulting in an estimated net saving of $201 million per annum, and reduce the social and economic burden of pain on individuals and the community[9].

4. **Invest $5 million over three years to develop training frameworks and programs that strengthen health professionals' competencies to deliver self-care education and engagement.** The initiative would support key workforce development agencies to develop and trial self-care education and engagement competencies across health professionals, to ensure Australia's healthcare workforce is equipped with the appropriate skills and techniques to support and facilitate greater self-care, and person-engaged care.

5. **Allocate funding for the staged roll out of a renumerated common ailment scheme system in community pharmacy.**
   A comprehensive pilot program conducted in the Western Sydney PHN demonstrated how a common ailments scheme, including pharmacist remuneration, would improve access to primary care, maintain the current standard of care and clinical outcomes for patients, reduce emergency presentations, and deliver potential net national healthcare savings of up to $1.26 billion per annum[10].

[9] PainAustralia's New Policy Proposal – Appendix 6.
[10] University of Technology: An Australian Minor Ailment Scheme - https://www.uts.edu.au/sites/default/files/2019-11/Executive%20Summary%20%28wl%29.pdf

Contents

Executive Summary **1**

About the Australian Self-Care Alliance **5**

Budget Recommendations: **6**

Invest $6 million over five years to develop and implement a digital health information accreditation scheme and a library of accredited digital health information apps. 6

Fund the national rollout of the Asthma Australia's AirSmart program. 8

Allocate funding to enhance Chronic Disease Management services available for suffers of chronic pain. 10

Invest $5 million over five years to develop training frameworks and programs that strengthen health professionals' competencies to deliver self-care education and engagement. 12

Allocate funding for the staged roll out of a remunerated common ailment scheme system in community pharmacy. 14

Appendices **17**

Understanding self-care as a health policy and practice tool 17

The health economics of self-care 18

Self-care for health in practice 20

2023 initiatives supporting self-care 22

The Self-Care Charter 23

Painaustralia – New Policy Proposal ..... **Error! Bookmark not defined.**

About the Australian Self-Care Alliance

The Australian Self-Care Alliance (the Alliance) is a collaboration between healthcare consumers, health promotion charities, policy experts and industry partners, that promotes the adoption of self-care and its implementation as a core element of all aspects of physical and mental health services and policies for Australia.

The Alliance is Australia's only peak self-care organisation for health and is registered as a Health Promotion Charity.

As a health policy collaboration, the Alliance acts as an advisor, mediator, and advocate for systemic changes in the delivery of health services towards greater self-care. While the term 'self-care' implies the responsibility of individuals, it cannot be simply reduced to a matter of personal responsibility and choice.

Individuals' potential to be informed and able to undertake self-care of their health is dependent on underlying environmental and external factors that sit beyond the individual. The Alliance was formed to advocate for the structural, cultural and policy changes required to support greater self-care in Australia's health and care systems.

To this end, the Alliance supported the development of the landmark report by the Mitchell Institute for Education and Health Policy, '*Self-care for health: a national policy blueprint'*[11] (the Blueprint). Launched by the then Minister for Health on 7 October 2020, the Blueprint outlines a national policy approach to building self-care capability and enhancing self-care activity in all aspects of health and health care and provides a framework for action.

As a health policy collaboration, the Alliance seeks to ensure that self-care policy is person-focused, healthcare-focused and system focused. We engage with national, state and territory peak consumer and carer organisations, health promotion charities, policy experts, supportive professional and industry associations, commercial organisations, all levels of government and other key stakeholders. In line with the World Health Organisation's *Ottawa Charter for Health Promotion*[12], together we seek to influence positive outcomes in public policy; enabling environments for self-care; community action for self-care personal self-care skills; and innovation at the highest level to generate improved health service delivery.

In 2023, the Alliance released the Self-Care Charter (Appendix 5), codifying exactly what self-care resources, skills and supports consumers' want and need to live well and create better health outcomes for themselves and their families. Developed in collaboration with Lived Experience Australia, the Self-Care Charter sets out 10 principles that consumers would like to see govern the delivery of self-care policy and practice in Australia.

The Self-Care Charter was endorsed by 34 of Australia's leading peak health bodies and patient organisations, acknowledging that self-care needs to be an accessible option for all Australians, no matter their health status, age or gender.

[11] Mitchell Institute for Education and Health Policy "Self-care and health: a national blueprint" - https://www.vu.edu.au/sites/default/files/mitchellinstitute-self-care-for-health-a-national-policy-blueprint.pdf
[12] World Health Organisation's Ottawa Charter for Health Promotion - https://www.who.int/teams/health-promotion/enhanced-wellbeing/first-global-conference

Budget Recommendations:

Invest $6 million over five years to develop and implement a digital health information accreditation scheme and a library of accredited digital health information apps.

Evidence of the efficacy of digital health interventions and innovations has been growing steadily. In 2016, the WHO has recognised the potential for technology to increase access to health information, improve health literacy and "promote positive changes in health behaviours and manage diseases"[13].

As confirmed by '*The Self-Care Opportunity*'[14], Australians are increasingly engaging in and managing their health through digital health technologies and resources;

- More than two thirds of Australians are consulting 'Dr Google' before seeking the advice of a doctor or pharmacist.
- 69% utilising eHealth options in the management of their health.
- 24% of Australians are monitoring their own health with phone apps and/or health trackers.
- 2 in 5 Australians read health information on social media platforms, either directly from their social feed or through patient/support groups

However, among the many challenges Australians face when utilising digital health technologies, is the ability to identify and source credible and quality information. Additionally, considering the established ability of social media to disseminate information, shape public perception, and influence individuals' health decisions, empowering Australians with the ability to access and verify accurate health information should be a public health policy priority.

The new Digital Health Blueprint 2023–2033 and action plan highlights the need for digital health tools to be trusted. A digital health information accreditation scheme and a curated library of accredited digital health information apps will deliver on this objective.

A concerted national effort is required to ensure Australians' have access to the reliability of health information, with '*The Self-Care Opportunity*' report finding:

- 52% have trouble identifying credible sources of digital information
- Only one in ten (9%) state they fully understand what they're reading, and
- Approximately three in ten Australians would be more likely to engage with digital health information and technologies if there was independent verification of its credibility.

Verification of efficacy and credibility is also of major concern when considering digital health interventions, many of which require individuals purchase devices/ accessories, software or a recurring subscription.

Greater utilisation and integration of credible, evidence-based and economically accessible digital self-care technologies and resources into chronic condition management and treatment plans would not only help improve patients' long-term wellbeing but could also improve medicines and treatment compliance. This could in turn could then reduce the likelihood of

[13] World Health Organisation, *139th Executive Board, 2016; Geneva, Switzerland - Mhealth: Use of Mobile Wireless Technologies for Public Health 27 May 2016.*
[14] The Self-Care Opportunity Report (2022) - https://www.chpaustralia.com.au/Tenant/C0000022/Documents/Self%20Care/The%20Self-Care%20Opportunity%20-%20Final%20Report.pdf

individuals developing preventable secondary conditions, including obesity, diabetes and depression[15].

However, there are over 350,000 apps in the Health & Fitness and Medical categories of app stores[16], yet there is no regulation of the development and evaluation of the content of these apps[17]. Patients and healthcare providers alike are overwhelmed and under-resourced to be able to find and use the best options.

Where there is a direct cost to consumers for a digital health product, it is appropriate that Government develop an accessible resource that allows consumers to confirm the intervention is evidence-based and credible.

This illustrates the importance of developing accessible, sustainable, and robustly evaluated online resources and evidence-based apps, which can be achieved through an expansion of the Australian Government's existing digital health infrastructure and supports.

Proposal in action:

Under this proposal, the Government would invest $6 million to develop and implement an opt in digital health information accreditation scheme and digital health information library, allowing in digital health information and services apps to apply for a 'health star rating'.

The Trusted Digital Identity Framework is "an accreditation regime which specifies the minimum requirements that Attribute Service Providers, Credential Service Providers, Identity Exchanges and Identity Service Providers are required to meet in order to achieve and maintain TDIF accreditation."[18] This Initiative would align very closely with the TDIF, which will be driven by the following principles: user centric; voluntary and transparent; service delivery focused; privacy enhancing; collaborative; interoperable; adaptable; and secure and resilient.[19]

In line with the approach taken in the United Kingdom (UK), this initiative would provide funding for a credible and credentialed NGO or government-funded digital health service, with the support of the Alliance in an advisory capacity, to develop, implement and administer the accreditation scheme for an initial five years, including:

1. Develop criteria for accreditation
2. Develop measures of evidence
3. To measure compliance with evidence standards and expectations
4. Develop a library of relevant apps that have met accreditation standards. The library would be easily accessible by citizens, health care providers and health-care users, and
5. Launch the 'trusted App library' via a social media campaign. App developers would be invited to opt-in to receive accreditation and join the library.

[15] Royal College of General Practitioners: Digital Technologies and Chronic Condition Management - https://www.racgp.org.au/getattachment/b1fc94dd-07d5-4eab-b585-c128342ce917/Digital-technologies-and-chronic-disease-managemen.aspx#:~:text=It%20has%20been%20suggested%20that,better%20supporting%20patient%20self%2Dmanagement.
[16] Research 2 Guidance., *Mhealth App Economics: Current Status and Future Trends in Mobile Health*. 2017.
[17] Bates, D.W., A. Landman, and D.M. Levine, *Health Apps and Health Policy: What Is Needed?* JAMA, 2018. **320**(19): p. 1975-1976.
[18] Trusted Digital Identity Framework Release Release 4 June 2021, version 1 - https://www.digitalidentity.gov.au/sites/default/files/2021-06/tdif-02-overview-release-4-v1.2.pdf
[19] Ibid.

Fund the national rollout of the Asthma Australia's AirSmart program.

To address the gap in Australians' understanding of the established health risks associated with air pollution and quality, and lack of consumer access to credible air quality information and guidance, Alliance member, Asthma Australia has taken the lead on developing and piloting a public education campaign and air quality app called 'AirSmart'.

Modelled on the highly respected and successful SunSmart UV Index program, AirSmart fills the need for community education and guidance around air quality which was revealed by the 2019–2020 bushfire smoke crisis. This need was recognised by the Royal Commission into National Natural Disaster Arrangements and the Final Report of the NSW Bushfire Inquiry following the 2019–20 bushfires. The need for access to air quality information and guidance will only increase as climate change continues to increase the frequency and severity of events causing poor air quality.

It was estimated that during the 2019–20 bushfires, the cost to Australian Government's for smoke-related health care was a record-breaking A$1.95 billion; this included approximately 3,230 hospital admissions for cardiovascular and respiratory disorders, 1,523 emergency attendances for asthma, and 429 smoke-related premature deaths.[20]

As Australia is continuing to experience longer and more severe bushfire seasons, these substantial economic and human costs from bushfire smoke are expected to dramatically increase over the coming years.

AirSmart was developed with the guidance of a panel of environmental and public health experts, including from the University of Sydney and the NSW Department of Planning and Environment. AirSmart was piloted in communities across southern NSW, ACT, and regional Victoria over a six-week period in July and August 2022. The pilot was evaluated and showed strong indications that Australians want access to local, responsive air quality information and tools. Engagement in the campaign, as shown by over 16,000 app downloads and 23,000 website views in just six weeks, suggests that air quality is an important issue for many Australians.

Proposal in action:

AirSmart includes an air quality public health campaign which raises awareness about air quality and promotes the AirSmart app as a source of air quality information:

- **The public health campaign** aims to raise community awareness about poor air quality, and how to interpret health advice, so people can protect themselves against exposure to air pollution and the associated health impacts. This evidence-based educational initiative is an Australian-first, using a mix of traditional and digital media channels to reach the full community. The creative process behind the AirSmart campaign included consumer research and was guided by environmental, public health and social marketing experts. The campaign includes 15 and 30 second television commercials, a radio commercial, social and digital assets, a website, billboards, and an app.

- **The AirSmart app** is a consumer tool for accessing local, real-time air quality information and related health advice. Asthma Australia used human-centred design principles to design the AirSmart app. The AirSmart app provides consumers with localised 'real-time' air quality, and strategies to avoid or minimise poor air quality exposure. The app also provides personalised notifications and health advice at specific air quality levels to provide consumers with specific daily advice about the most effective protection.

[20] Unprecedented health costs of smoke-related PM2.5 from the 2019–20 Australian megafires: https://www.nature.com/articles/s41893-020-00610-5

Considering the return of the El Nino-Southern Oscillation, and bushfire season modelling for the coming years, and the urgency to provide Australians with access to air quality information and guidance, AirSmart provides a solution to reduce the impact of poor air quality on impacted populations.

Asthma Australia is seeking funding contributions from all governments – state, territory and federal – towards a national AirSmart campaign. The investment requested in this proposal would fund a national campaign. If additional funding was received from states and territories, this would enable increased investment during air quality emergency incidents and ongoing advertising and promotion through the year.

Asthma Australia has proposed two options for funding that would enable the activation of AirSmart in the months of November and December in jurisdictions including Sydney, Regional NSW, Regional Victoria, Brisbane, and Regional Queensland, with television the main difference which will impact reach delivery and recall of campaign.

Option 1 $12,767,760 (including television); or Option 2 $6,481,760 (excluding television) over two years for a national roll-out of Asthma Australia's AirSmart public education campaign to reduce the impacts of poor air quality.

As an evidence-based and credible digital self-care intervention and accessible consumer health tool, Asthma Australia's AirSmart program aligns with and compliments the outcomes of the National Preventive Health Strategy and Digital Health Blueprint 2023–2033, and the stated objectives of the National Health Literacy Strategy and National Consumer Engagement Strategy.

Allocate funding to enhance Chronic Disease Management services available for suffers of chronic pain.

For too long, many Australians living with pain have been unable to access high quality pain assessment and management, whether due to cost, geographic barriers, low awareness of treatment options, or lack of access to health professionals with the right knowledge and skills. The New Policy Proposal (Appendix 6) from leading pain consumer advocate, and Alliance member, Painaustralia, would make an effective contribution to addressing these issues by doubling their access to multidisciplinary care through the chronic disease management (CDM) framework.

Currently, only 1 out of 100 Australia's living with chronic pain will receive multidisciplinary care[21].

Pain research over the last 30 years supports the complexity of chronic pain and the need for pain management approaches to encompass multidisciplinary or integrated care models[22].

Multidisciplinary pain management interventions have been found often to be superior to standard treatment of pharmaceutical and invasive care for chronic pain management[23]. In its current form, Medicare does not support this best-practice model, leading to unnecessary use of hospital-based services and more significantly, an historic over-reliance on medication including opioids. Data from the Cost of Pain report reveals that 68 per cent of pain management consultations will end with a GP prescribing pain medication only. Another 13 per cent will end in imaging, but less than 15 per cent can hope to be referred to an allied health professional[24]. This unfortunately means that for the 3.4 million people living with chronic pain, access to best practice care is challenging at best, and fatal at worst.

Proposal in action:

Painaustralia's policy proposal (Appendix 6), identifies three overarching priority policy enhancements to help improve the CDM framework and its services to provide better primary and pharmacy care for those Australians living with chronic pain and to minimise the social and economic burden of pain on individuals and the community.

i. Change in scope, coverage and eligibility for CDM services;
ii. Promoting health professionals authorised and qualified to complete General Practitioner Management Plans and Team Care Arrangements; and
iii. Development and delivery of specialist chronic pain education and training.

Specifically, Painaustralia's NPP makes specific recommendations to enhance the CDM Framework. This includes:

- increasing the number of allied health visits under a CDM Referral to 10 per year;
- supporting the development and delivery of specialist chronic pain education and training for health professionals in the primary care setting; and
- supporting the use of the Medicare Benefits Schedule CDM Framework to treat and manage chronic pain not only associated with chronic disease but, also with other medical conditions and, as a condition in its own right.

Furthermore, it also recommends that any proposed changes to the Medicare CDM Framework be subject to an independent assessment and evaluation for an initial period of two budget cycles.

[21] Painaustralia Annual Report 2022–23, available at www.painaustralia.org.au
[22] National Academies of Sciences, Engineering, and Medicine. (2019) *The Role of Nonpharmacological Approaches to Pain Management: Proceedings of a Workshop,* Washington DC: The National Academies Press, p. 1.
[23] Painaustralia and Deloitte Access Economics. (2019) *The cost of pain in Australia*, Report commissioned by Painaustralia, pp. viii–ix.
[24] Painaustralia and Deloitte Access Economics. (2019) *The cost of pain in Australia*, Report commissioned by Painaustralia.

It would also be an enhancement to the current team care arrangements and chronic disease management programs if the GP could be encouraged to review the plan during the 12 months and seek additional access if needed to specific allied health supports.

As demonstrated by the data outlined in the PainAustralia proposal, doubling Australians' access to multidisciplinary care to treat chronic pain could be achieved with a $70 million per year investment. Greater access to multidisciplinary care could deliver $3.7 million in savings to the health system (net of intervention costs) while reducing absenteeism ($65 million) and improving wellbeing ($203 million in QALYs gained). Overall, the benefit to cost ratio is estimated to be 4.9 to 1[25].

There is consistent evidence that multidisciplinary care models are cost effective. Evidence-based research estimates a saving of $8,100 per patient, and savings of $356,288 per person over a patient's lifetime compared to conventional medical treatment.[21]

The net cost/resource requirements for the proposal would be accommodated within the broader MBS budget, with offsetting savings accruing from reductions in unnecessary health care presentations, inappropriate use of opioids, productivity gains, and importantly through the strengthening and enhancement of multidisciplinary pain management in the primary care setting. For example, the roll-out of a pain specialist designed and led national GP training program, would cost $45 million but save $209 million in overdose-related costs.

[25] Painaustralia and Deloitte Access Economics. (2019) *The cost of pain in Australia*, Report commissioned by Painaustralia, p. 67.

Invest $5 million over five years to develop training frameworks and programs that strengthen health professionals' competencies to deliver self-care education and engagement.

Enabling greater self-care and consumer empowerment in health requires investment to ensure Australia's healthcare workforce is equipped with the appropriate skills and techniques to support and facilitate greater self-care, and person-engaged care.

The historic lack of attention, in health policy and practice, on an active role for health consumers, and how primary and secondary care health services and professionals can better facilitate person-engaged care, runs counter to current ideas of best-practice for effective health management, which advocates for bidirectional, collaborative, and patient engaged care.

It also contributes to an ongoing frustration expressed by clinicians of being unable to address the underlying cause of many of the health problems they encounter among their patients, and the recognition that greater involvement of individuals and communities in health and care policies, will likely result in more meaningful, long-term change.

As articulated in the Mitchell Institute's report, *Self-care for health: A national policy blueprint*[26]:

> *"Health professionals and service providers also play an essential role in supporting and facilitating self-care by healthcare consumers."*

Health and health care should be regarded as co-produced by health professionals with individuals and communities, and as such, training frameworks and programs for healthcare providers to better enable, encourage and support this dynamic are urgently required.

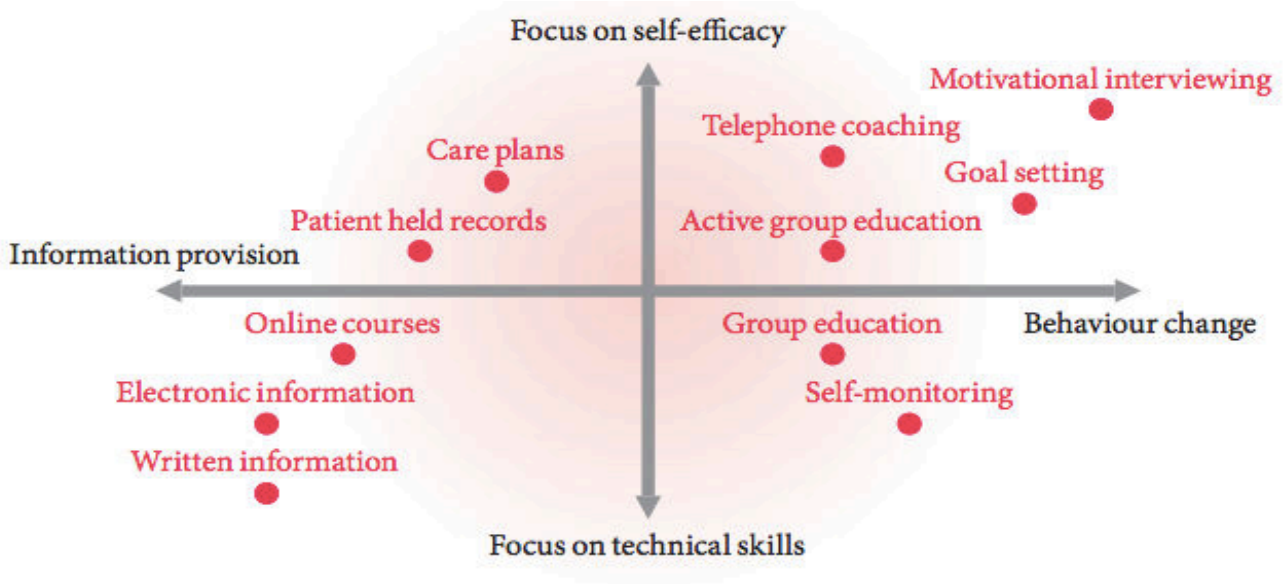


Figure 4 - Strategies to support self-care for health[27]

[26] Mitchell Institute for Education and Health Policy "Self-care and health: a national blueprint" - https://www.vu.edu.au/sites/default/files/mitchell-institute-self-care-for-health-a-national-policy-blueprint.pdf

[27] De Silva, D., *Helping People Help Themselves. A Review of the Evidence Considering Whether It Is Worthwhile to Support Self-Management*. 2011, The Health Foundation: London.

Healthcare providers need to be equipped the appropriate skills and techniques to support self-care for health, which often entails helping people to think about their strengths and abilities and identifying their specific needs and changes required to maintain good health and wellbeing[28]. This requires:

(i) care planning,

(ii) collaborative agenda setting,

(iii) recognising and exploring ambivalence, and

(iv) goal setting, action planning and follow-up.

Furthermore, to adequately support the self-care of their patients, healthcare providers need to be able to effectively communicate and tailor the level of a person's involvement based on the individual's ability to practice self-care for their health[29].

Proposal in action:

Through this initiative, the Government would invest $5 million over five years to develop self-care education and engagement competencies in all health professional education and continuing professional development courses – through a grants-based program and appropriate eligibility criteria for health professional membership and training programs.

Among Australia's health and care workforce, there is an acknowledgment of this gap in healthcare professional education and training. In particular, Alliance member Australian Primary Health Care Nurses Association has included a similar proposal in their *Pre-Budget Submission*.

Embedding these competencies in all health professional education and continuing professional development courses is a critical step towards upskilling the existing and future Australian health care workforce to deliver core elements of the National Health Literacy Strategy, and National Consumer Engagement Strategy. Training frameworks and improved competencies for providers to deliver self-care information will help deliver the full benefits of MyMedicare.

[28] De Iongh, A., P. Fagan, J. Fenner, and L. Kidd, *A Practical Guide to Self-Management Support. Key Components for Successful Implementation*. 2015, The Health Foundation: London.
[29] The Royal Australian College of General Practitioners, *Putting Prevention into Practice: Guidelines for the Implementation of Prevention in the General Practice Setting*. 2018, RACGP: East Melbourne, Victoria.

Allocate funding for the staged roll out of a remunerated common ailment scheme system in community pharmacy.

Annually in Australia it is estimated[30] that unnecessary GP and emergency presentations for minor conditions that, which fall within the current scope of pharmacist's knowledge and training to treat, are costing Australian Governments up to $1.67B per annum.

The Australian Institute of Health and Welfare report, '*Use of emergency departments for lower urgency care: 2015-16 to 2017-18*', found that presentations to hospital emergency departments for lower urgency care may be avoidable through provision of other appropriate health services in the community[31].

As acknowledged by establishment of the *Unleashing the Potential of our Health Workforce Review*, the provision of a wider variety of primary health services, which requires systems and funding models that allow all highly qualified and trusted health care professionals to work to their full scope of practice, is critical enabler that will reduce unnecessary pressure on our emergency care services while ensuring Australians have access to the appropriate level of care for their ailment.

The Alliance commends the Albanese Government decision to initiate the review, which we believe has the potential to disrupt the siloed delivery of health care and services that impedes greater self-care, and a healthier future for all Australians. Furthermore, it opens the door to greater utilisation of place-based and community-led initiatives based on the specific needs and challenges of a community or vulnerable health populations. Community pharmacy is an integral part of the Australian primary health system and with the appropriate supporting systems, a sustainable funding framework and pre-agreement with physicians has the potential to facilitate an improved flow of patients and information transfer within the health system30F[32].

A comprehensive 2019 evaluation[33] of a minor ailments scheme (hereinafter referred to as a common ailments scheme) conducted by the University of Technology Sydney estimated that between $380M - $1.26 billion (net) could be saved annually if a remunerated common ailments scheme in community pharmacy was funded and implemented nationally.

Common ailments are defined as "conditions that are self-limiting, with symptoms easily recognised and described by the patient and falling within the scope of pharmacist's knowledge and training to treat"[34].

Evaluating an integrated primary care pilot program in the Western Sydney Primary Health Network (WSPHN), researchers estimated that 7-21.2% percent of all GP consultations and 2.9-11.5% percent of all emergency department services in Australia could be safely transferred to a community pharmacy.

Annually in Australia, it is estimated, for self-treatable conditions there are:

- 232,507 - 922,012 unnecessary visits to emergency departments at a cost of up to $493.8 million

[30] University of Technology: An Australian Minor Ailment Scheme - https://www.uts.edu.au/sites/default/files/2019-11/Executive%20Summary%20%28wl%29.pdf
[31] Australian Institute of Health and Welfare: Use of emergency departments for lower urgency care: 2015-16 to 2017-18 - https://www.aihw.gov.au/reports/primary-health-care/use-of-ed-for-lower-urgency-care-2018-19/contents/about
[32] University of Technology: An Australian Minor Ailment Scheme - https://www.uts.edu.au/sites/default/files/2019-11/Executive%20Summary%20%28wl%29.pdf
[33] University of Technology: An Australian Minor Ailment Scheme - https://www.uts.edu.au/sites/default/files/2019-11/Executive%20Summary%20%28wl%29.pdf
[34] Aly M, Benrimoj SI. Review: Enhancing primary health care: the case for an Australian minor ailment scheme. University of Technology Sydney; 2015.

- 8.8 million - 26.6 million unnecessary GP appointments at a cost of up to $1.2 billion.

Researchers determined there was "good evidence that the clinical advice provided by community pharmacists regarding symptoms of minor illness will result in the same health outcomes as if the patient went to see their GP or attended the emergency department".

The model developed for the pilot program was collaboratively designed, applying guiding principles of integration of community pharmacy practice into the health care system, collaboration with general medical practitioners and patients, ensuring high quality and safe use of nonprescription medicines and, appropriate treatment of common ailments.

Proposal in action:

Under the proposed model, pharmacists would be remunerated for services related to the assessment, triage and management of patients presenting with minor ailments; reducing expenditure on more costly health service interventions, and improving the efficiency and accessibility of primary health services for all Australians.

Based on this model, by reinvesting between $131 - $399 million of the revenue generated by the double dispensing reforms into the national roll out of a remunerated common ailments scheme in community pharmacy, up to $1.26 billion in direct savings could be returned to general revenue through reduced unnecessary GP and emergency presentations.

The UTS evaluation of the pilot program's economic value concluded that a common ailments scheme is a cost-effective alternative to the traditional primary care model, and estimated the potential clinical and economic impact of national implementation *(Figure 3 – Projected cost reductions from national implementation)*.

		Estimated annual community pharmacy manageable services			Cost reductions	
		GP services (n)	ED services (n)	Combined services (n)	Overall cost reduction potential with shift of services to pharmacy	Overall cost reduction potential if AMAS is paid for
National	Maximum	26,586,994	922,012	27,509,006	-$1,665,411,901	-$1,266,806,407
	Minimum	8,778,725	232,507	9,011,232	-$511,373,307	-$380,800,559
NSW	Maximum	8,831,535	331,233	9,162,768	-$572,069,660	-$439,301,145
	Minimum	2,916,073	83,528	2,999,601	-$174,621,799	-$131,157,576
WSPHN	Maximum	1,271,558	11,454	1,283,012	-$62,356,841	-$43,765,997
	Minimum	419,854	2,888	422,742	-$20,096,087	-$13,970,549

Abbreviations: *AMAS: Australian minor ailments scheme; AUD: Australian dollars; ED: emergency department; GP: general practitioner; NSW: New South Wales; WSPHN: Western Sydney primary health network*

Figure 3 – Projected cost reductions from national implementation

Innovation, integration, collaboration, communication and teamwork will be vital to provide effective healthcare in the future. Redeploying Australia's existing healthcare resources, allowing, incentivising and remunerating pharmacists to operate closer to the top of their scope of

practice, is a pragmatic and cost-effective method for addressing one of the significant challenges currently facing Australia's stretched public hospital systems. More broadly, it will increase the efficiency of the health system through improved service navigation to guide the patient towards the most appropriate care destination.

Given a comprehensive and successful trial has already been conducted and evaluated, The Alliance firmly believes the policy is ready for national implementation.

This proposal is also supported in Pre-Budget Submission of Alliance members, the Pharmaceutical Society of Australia and Consumer Healthcare Products Australia.

Appendices

Understanding self-care as a health policy and practice tool

The World Health Organisation defines self-care as "the ability of individuals, families, and communities to promote health, prevent disease, and maintain health and to cope with illness and disability with or without the support of a health-care provider", and in 2009, concluded that self-care should be a fundamental component to achieving both individual and structural health goals[35].

Self-care, as a health policy and practice tool, is a comprehensive, evidence-based, and complementary component of health, and offers an explicit strategy to:

- foster more independent, empowered, and efficient healthcare consumers,
- support a more health resilient population, and limit the impact of infectious diseases,
- enhance preventive health engagement and action,
- support better acute and chronic condition management, and
- reduce the unsustainable burden currently being placed on Australia's emergency health services without compromising health outcomes.

Self-care for health also encompasses the knowledge, skills and activities individuals can utilise every day to enhance their mental and physical health and wellbeing, prevent disease, limit illness, and use healthcare services effectively *(Figure 1 – The Self-Care Matrix)*.

Figure 1 – The Self-Care Matrix

The Self-Care Matrix also illustrates how, despite the term 'self-care' implying an autonomous focus on the actions of individuals, it cannot simply be reduced to a matter of individual

[35] World Health Organisation. Self-care in the context of primary health care - https://apps.who.int/iris/handle/10665/206352

responsibility and choice; and is in fact significantly influenced by systematic and structural factors that shape an individuals' capacity to engage in their health[36].

As stated in the Mitchell Institute's report, *Self-care for health: A national policy blueprint*[37]:

> *"It is important to think about self-care from two (2) complementary perspectives: one focused on the capacity of individuals to self-care, and another focused on how self-care is supported through policy and within the health system."*
>
> *"Governments and policymakers are largely responsible for creating environments which either inhibit or enable self-care, and play a major role in the development of self-care capabilities at the population level.*
>
> *Health professionals and service providers also play an essential role in supporting and facilitating self-care by healthcare consumers. Other key self-care stakeholders include families, communities and health and industry organisations."*

Effective self-care involves a collaboration between individuals, communities and healthcare services. This, in turn, requires a health system and social context in which self-care is acknowledged, supported and enabled as a key component of health care.

Enabling greater self-care and patient empowerment in health requires not only structural and cultural changes within our health and care systems to encourage an environment that facilitates shared decision-making (health professionals and patients working together to make health-related decisions), but also, targeted initiatives and policy support to ensure individuals have the knowledge and skills required to be an informed advocate for, and active participant in their own health.

The COVID-19 pandemic has demonstrated that, by providing individuals with information and support they require to prevent infection and illness and engaging them as partners in their own health management, health authorities can reduce preventable health problems and address public health priorities.

However, despite Australians' growing capacity and enthusiasm to manage their health more actively, our current primary and secondary care structures and culture do not facilitate or incentivise encouragement or support consumer engagement and empowerment in health.

Dedicated investment by the Australian Government, along with a systematic approach to build self-care capability and enhance self-care activity in all aspects of health and healthcare, will enable Australia to capitalise on the health, economic and productivity benefits available through supported self-care for health.

The health economics of self-care

Ensuring the long-term sustainability of Australia's world class healthcare system and services is increasingly of concern to not only policy and key decision makers, healthcare providers and stakeholders, but importantly, everyday Australians who rely on the essential safety net and services that Medicare provides.

[36] Mitchell Institute for Education and Health Policy "The State of Self-Care in Australia" - https://www.vu.edu.au/sites/default/files/the-state-of-selfcare-in-australia.pdf
[37] Mitchell Institute for Education and Health Policy "Self-care and health: a national blueprint" - https://www.vu.edu.au/sites/default/files/mitchell-institute-self-care-for-health-a-national-policy-blueprint.pdf

Expenditure on healthcare, in the long term, is projected to continue to rise faster than both the national income and personal incomes[38].

According to the Australian Institute of Health and Welfare (AIHW)[39], in 2019-20 Australia spent $205.5 billion on health; including money spent by all levels of governments as well as non-government entities such as individuals, private health insurers, and injury compensation insurers. This equates to an average of $7,926 per person on healthcare each year.

Additionally, ill health and out of pocket medical expenses continue to be leading causes of personal bankruptcies in Australia[40].

These issues are further compounded by Australia's aging population[41], and ongoing epidemic of preventable and chronic physical and mental conditions[42].

A fundamental re-orientation of our healthcare system is long overdue as Australia's current health and care services are geared to primarily engage individuals when they are already unwell – often with preventable conditions, rather than incentivising practice models that help people to be healthier and thus avoid preventable health risks and conditions.

Self-care is a cost-effective and logical approach that can reduce the spiralling costs of disease burden, help Australians maintain healthier and more productive lives, and support the long-term sustainability of Australia's health and care systems. If properly supported, self-care can be a game changer for public health with research showing:

- empowered health consumers, who take greater ownership of their journey, achieve better health outcomes[43]
- individuals who lack the skills to undertake self-care effectively incur higher health service costs[44].

Furthermore, recent economic modelling[45] shows that greater self-care has the potential to save Australia's healthcare system between $1,300-$7,515 per hospital patient, per year, and significantly lower hospital readmission rates[46].

Greater utilisation and integration of all our primary care assets and resources is also urgently required to guide patients to the most appropriate primary and/or secondary care setting for their ailment, and reduce Australian and State Government expenditure on unnecessary and costly emergency care presentations.

---

[38] Reserve Bank of Australia: Economic Outlook 2022 - https://www.rba.gov.au/publications/smp/2022/aug/pdf/05-economic-outlook.pdf
[39] Australian Institute of Health and Welfare (2022). Health Expenditure Australia 2019-20 - https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure
[40] Australian Financial Security Authority - https://www.afsa.gov.au/statistics/causes-personal-insolvency
[41] Australian Bureau of Statistics: Population Projections 2017 - https://www.abs.gov.au/articles/population-aged-over-85-double-next-25-years
[42] The Australian Prevention Partnership Centre: What is the burden of chronic disease? - https://preventioncentre.org.au/about-prevention/what-is-the-burden-of-chronic-disease/
[43] PricewaterhouseCoopers: The future of health in Australia - https://www.pwc.com.au/health/health-matters/the-future-of-health-in-australia.html
[44] - Hibbard, J.H., J. Greene, and V. Overton, Patients with Lower Activation Associated with Higher Costs; Delivery Systems Should Know Their Patients' 'Scores'. Health Affairs, 2013. 32(2): p. 216-222. - Brady, T.J., L. Murphy, B.J. O'Colmain, D. Beauchesne, B. Daniels, M. Greenberg, M. House, and D. Chervin, A Meta-Analysis of Health Status, Health Behaviors, and Health Care Utilization Outcomes of the Chronic Disease Self-Management Program. Prev Chronic Dis, 2013. 10: p. 120112
[45] Mitchell Institute for Education and Health Policy "Self-care and health: a national blueprint" - https://www.vu.edu.au/sites/default/files/mitchellinstitute-self-care-for-health-a-national-policy-blueprint.pdf
[46] Roughead, L., S. Semple, and E. Rosenfeld, Literature Review: Medication Safety in Australia. Sydney: Australian Commission on Safety and Quality in Health Care, 2013.

Annually in Australia, it is estimated[47] that there are up to 922,012 unnecessary visits to emergency departments for self-treatable conditions, at a cost of up to $493.8M.

Beyond the budgetary implications, which are significant, these unnecessary emergency presentations also highlight how the structures of Australia's primary care environments and service have resulted, in some spaces, in the underutilisation of Australia's healthcare workforce and resources; most notably, community pharmacy.

Researchers have estimated that 7-21.2% percent of all GP consultations and 2.9-11.5% percent of all emergency department services in Australia could be safely transferred to a community pharmacy[48].

Self-care for health in practice

Empowering individuals to have greater involvement in, and ownership of their physical and mental health management and outcomes should be a defining characteristic of Australia's health and care systems, services, and supports.

Self-care is the most logical, simple, cost-effective and comprehensive approach to help drive individual and community engagement and empowerment in health care. If properly supported, self-care could be a game changer for public health, with benefits being shared by individuals, communities, and government.

Action to comprehensively engage Australians in their health must be systemic, multifaceted, continuous, and lifelong to ensure individuals are equipped, supported, and empowered to be their own health advocates. Embedding greater self-care in health care and public policies is required to facilitate and support this objective.

The Australian Government has the opportunity to develop a systematic approach to build self-care capability and enhance self-care activity in all aspects of health and healthcare.

The landmark report by the Mitchell Institute for Education and Health Policy, '*Self-care for health: a national policy blueprint'*[49], outlines a national policy approach to building self-care capability and enhancing self-care activity in all aspects of health and health care, and provides a framework for action *(Figure 2 - Self-Care Policy Blueprint Outline)*.

[47] University of Technology: An Australian Minor Ailment Scheme - https://www.uts.edu.au/sites/default/files/2019-11/Executive%20Summary%20%28wl%29.pdf
[48] University of Technology: An Australian Minor Ailment Scheme - https://www.uts.edu.au/sites/default/files/2019-11/Executive%20Summary%20%28wl%29.pdf
[49] Mitchell Institute for Education and Health Policy "Self-care and health: a national blueprint" - https://www.vu.edu.au/sites/default/files/mitchell-institute-self-care-for-health-a-national-policy-blueprint.pdf

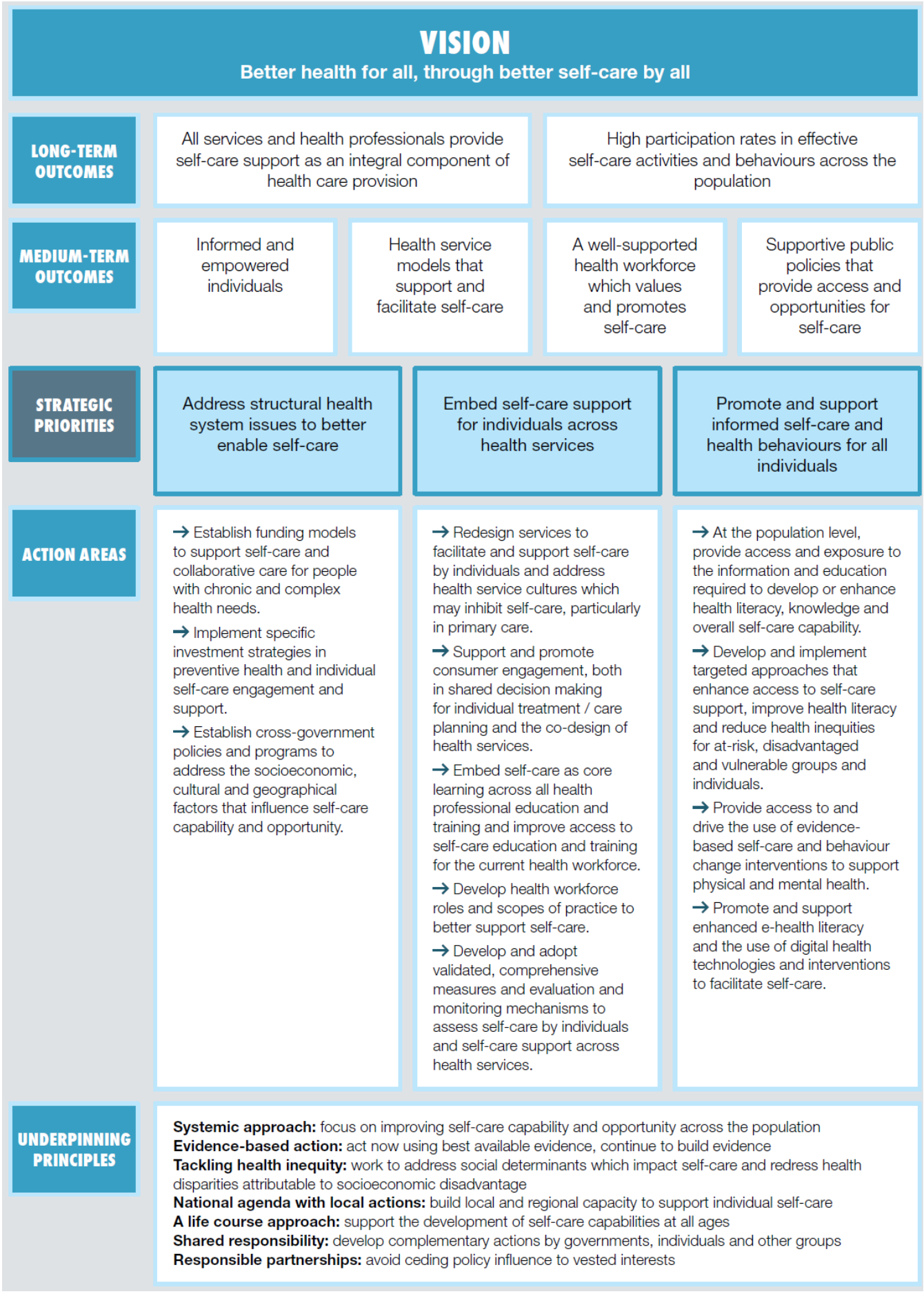


Figure 2 - Self-Care Policy Blueprint Outline

Led by leading public health policy expert, Professor Rosemary Calder AM, and endorsed by more than 50 health experts and stakeholders, the Blueprint offers a suite of evidence-based, feasible policy proposals to support self-care through health policy and practice, developed in collaboration with a network of health, self-care and policy experts.

The Blueprint outlines nine priority policy proposals for implementation, combined with the structural policy approaches recommended, these proposals will:

- improve health literacy for all
- build self-care into health care practice
- enable consumers to be active partners in health care
- assure the quality and accessibility of digital health information, and
- develop measures for individual self-care and self-care support by health services.

However, as the Blueprint makes clear, the benefits associated with self-care cannot be achieved for the whole population through a singular focus on individuals' health behaviours and lifestyle choices. Equal focus should be applied to enable and facilitate the provision of self-care support throughout the health system and broader community, including targeted approaches for individuals and groups requiring the most support to effectively self-care.

Each proposal will make a difference. Combined, however, the proposals have the potential to improve the health of all Australians, particularly disadvantaged, vulnerable and priority health populations, through the prevention and better management of disease and decrease health inequities by reducing the impact of the social determinants of health. As such, the Alliance strongly recommends the Blueprint policy proposals be implemented as a matter of priority.

2023 initiatives supporting self-care

Over 2023, the Albanese Government has promoted a self-care agenda through a range of policy initiatives. Three examples are cited below.

The introduction of MyMedicare provides incentives for general practices to work to improve consumers' capacity to manage their own health and provides rewards for better health outcomes. Our recommendation to develop training frameworks and programs that strengthen health professionals' competencies to deliver self-care education and engagement will be of great benefit to MyMedicare consumers.

The new Digital Health Blueprint 2023–2033 and action plan provides a framework a more person-centred, connected, and sustainable health system for Australians. Our recommendation to develop and implement a digital health information accreditation scheme and a library of accredited digital health information apps will help support the Blueprint.

Further, the government's plan to ensure diagnostic imaging and pathology results are available to consumers through My Health Record will save consumers time, money and pain, and ensure better health outcomes.

Self-care is for us all

Through screening, early detection, risk reduction, early intervention, collaborative relationships with doctors and others and management of chronic health conditions means I am practicing good self-care.

I need:

KNOWLEDGE through clear, understandable information to helpt me recognise health risks, encourage me to make changes and give me confidence

- Access to appropriate and evidence-informed information and support improve my practice of self-care
- Public messages about health conditions lessen stigma and identify opportunities to reduce risk factors that assists me to be as healthy and resilient as I can be.

ACCESS to self-care support that is right for me no matter who I am, where I live, where I have come from, how old I am or how much money I have.

- Tailored approaches, connections, and support for selfcare interventions and practice are available to me if I live in a rural or remote area, am a First Nations Person, culturally and linguistically diverse, socioeconomically disadvantaged, how old I am or identify with any other vulnerable group.

CHOICES to make my own decisions about my wellbeing with health care providers to keep me as well as I can be

- I can decide about my wellbeing, and treatment preferences.

OPPORTUNITIES to speak up for myself and to include others in discussions and decisions

- My views are respected; I can ask questions and I can include my family, carers, kin, or main support people in the discussions if I want them involved.

A NATIONAL SELF-CARE STRATEGY that ensures I have focused, responsive, accountable, and effective self-care

It will support me by:

- influencing change through evidence-based self-care information, education, guidelines and resources for me, my family, communities and for health services and professionals
- developing assessment tools and evaluation measures, policy development and leadership to ensure I have a responsive health system
- facilitating cost effective self-care initiatives that I can afford
- housing a national digital health, information, and resource library that I and others can access
- supporting government decision makers at all levels to include health in all departmental policies to promote good health for me and reduce risk factors for poor health

E-HEALTH TECHNOLOGIES that give me easy 24/7 access to reliable information

- That's credible, quality, appropriate models of self-care, delivered through digital health, telehealth, online or web-based resources for health advice and support that I can access anytime
- The models are underpinned by accepted Australian national quality standards

LOW-COST care that lessens the money I have to spend

- Through flexible funding models that support my self-care and helps me manage my chronic and complex health needs
- That provide value, are accessible, and reduce out of pocket costs to me

HEALTH CARE WORKERS providing advice and support relevant to me and my values and using their training in self-care

- Competent, skilled, healthcare and lived experience workers help me make sound decisions relating to good self-care practices, support my decisions, and promote, initiate, and facilitate self-care support in a shared decision-making capacity with me

SERVICES WORKING TOGETHER to keep me living as well as possible throughout my life

This will help me by:

- Coordinated and collaborative health services across my life span
- Improving integration between community health agencies and beyond
- Recognising the impact of social factors on my health
- Addressing social and economic impacts if they relate to me
- Improving population health for me and others

RESEARCH that gives me confidence that I will get the best care I need based on the latest evidence

- Investing in evidence-based research, including lived experience evidence, informs best practice models for me and the healthcare system.

Supporters

AHC & NADIES PLACE PTY LTD
ONE DAY AT A TIME

Australian Patients Association

apna
Supporting nurses in primary health care

Arthritis AUSTRALIA

ASTHMA AUSTRALIA

ausEE Inc.
a charity dedicated to improving lives affected by an eosinophilic disease

cancer voices australia

Care Opinion Australia

Consumer Healthcare Products Australia

CoMHWA

Eastern Health

emerge australia

EPILEPSY FOUNDATION

genetic alliance australia

Haemochromatosis Australia
Inherited Iron overload disorder

HCF

helping minds

hepatitis australia

Huntington's Australia

HDNA Huntington's Disease Network of Australia

IDFA Immune Deficiencies Foundation Australia

Lived Experience AUSTRALIA

Macular Disease Foundation AUSTRALIA

mental health families & friends TASMANIA
Your trusted voice in mental health

MUSCULAR DYSTROPHY AUSTRALIA

NORTHERN TERRITORY MENTAL HEALTH COALITION

painaustralia

Patient Voice Initiative

Private Healthcare Australia
Better Cover. Better Access. Better Care.

Queensland Mental Health Commission

Roses in the Ocean
stemming the tide of suicide

Stroke FOUNDATION

zero suicide

For more information about the Australian Self-Care Alliance, the Self-Care Charter or to download the Self-Care Charter Poster scan the QR code or go to:
www.selfcarealliance.org.au

SCAN ME TO LEARN MORE

Lived Experience AUSTRALIA

The development of this Charter was led by Lived Experience Australia in consultation with people who have lived experience of self-care of health conditions across Australia

painaustralia

New Policy Proposal:

Changing the way that chronic pain is perceived and treated in the health system

Enhancing the scope and coverage of chronic disease management services

walkmypain.com.au

Contents

About Painaustralia 2
Policy allies 3
Policy Coalition Allies 3
Clinical Advisory Council 2023—Painaustralia 3
Glossary 4
1. Policy proposal 5
1.1 Policy scope 5
1.2 Chronic Disease Management Services 6
2. Policy purpose 7
3. Rationale 8
3.1 Multidisciplinary chronic pain management 8
3.2 Allied health services and chronic disease management 10
4. Priority policy enhancements 12
4.1 Change in scope, coverage and eligibility for CDM services 12
4.2 Promoting health professionals authorised and qualified to complete GPMPs and TCAs 13
4.3 Development and delivery of specialist chronic pain education and training 13
5. Recommendations 15
6. Net cost/resource requirements 16
6.1 Enhancement of the CDM Framework 16
6.2 The cost of pain in Australia 17
6.3 Women and chronic pain 18
Lead policy contact 19

About Painaustralia

Painaustralia is the national peak organisation working to improve the lives of people with chronic pain, their families and carers, and to minimise the social and economic burden of pain on individuals and the community. Our aim is to have the voice of people living with pain represented and heard in all aspects of health policy and decision-making.

Painaustralia is supported in its national peak role by a range of cooperative policy allies and alliances that are aligned with its priorities, policy frameworks and initiatives.

The work of Painaustralia is also supported by the *Parliamentary Friends of Pain Management Group*[1]—a non-partisan group open to all Senators and Members. For the 47th Parliament, this group is co-chaired by Senators Hellen Polley (Labor) and Wendy Askew (Liberal).

> *Right now, 3.4 million Australians are living with chronic pain. It's debilitating for those people, for a whole host of reasons that are well known. Carers, families and friends are also impacted. As are medical centres, hospitals, workplaces and economies. The impacts of pain run deep and wide.*
>
> The Governor-General of the Commonwealth of Australia
> Launch of the Parliamentary Friends of Pain Management Group, and Painaustralia Morning Tea, Canberra
> 20 October 2020

[1] Parliamentary Friends of Pain Management Group <https://www.aph.gov.au/about_parliament/parliamentary_friendship>, accessed 6 August 2023; <https://www.painaustralia.org.au/media-document/enews-1/enews-2020/issue-98/launch-of-parliamentary-friends-of-pain-management-group>, accessed 6 August 2023.

Policy allies

Policy Coalition Allies

The policy coalition allies are an alliance of individuals and organisations working to improve the way that chronic pain is perceived and treated in the health system. For the purposes of this policy proposal the Policy Coalition is focused on enhancing the scope and coverage of chronic disease management services. It includes the following allies:

- Faculty of Pain Medicine (FPM) of the Australian and New Zealand College of Anaesthetists (ANZCA)
- The Royal Australian College of General Practitioners (RACGP)
- Australian College of Nursing (ACN)
- Australian Medical Association (AMA)
- Chronic Pain Australia (CPA)
- Australian Pain Society
- National Pain Research Alliance
- Pain Revolution
- Pharmacy Guild of Australia
- Australian Practice Nurses Association (APNA)
- Australian Psychological Society (APS)—TBC
- The Australian Clinical Psychological Society (ACPS)—TBC
- Pharmaceutical Society of Australia—TBC
- Practice Managers Association—TBC

Clinical Advisory Council 2023—Painaustralia

- Giulia Jones—Chief Executive Officer, Painaustralia.
- Dr Chris Hayes—Pain medicine physician; former Vice-Dean of the Faculty of Pain Medicine, ANZCA; and member of the Painaustralia Board.
- Associate Professor Malcolm Hogg—Specialist pain management physician; Clinical Associate Professor, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne; past president of the Australian Pain Society; and former member of the Painaustralia Board.
- Christine Collins—Advanced Practice Nurse; Nurse Educator; and representative of the Australian College of Nursing (ACN).
- Anthony Tassone—community pharmacist; Victorian Branch President of the Pharmacy Guild of Australia; Deputy Chair of the Pharmacy Guild of Australia.
- Dr Ruth Hardman (PhD)—APA pain physiotherapist; Clinical Lead: Pain Rehabilitation Service, Sunraysia Community Health Services (SCHS) Mildura; Researcher in chronic disease and health equity, SCHS/La Trobe University School of Rural Health.
- Dr Antonio Di Dio—Medical Doctor; former Australian Medical Association (ACT) President; Director of Professional Services Review for GPs; and practicing GP.
- Zoe Harper—Physiotherapist; and representative of the Australian Physiotherapy Association (APA).

Glossary

ACN—Australian College of Nursing

AIHW—Australian Institute of Health and Welfare

AMA—Australian Medical Association

ANZCA—Australian and New Zealand College of Anaesthetists

APA—Australian Physiotherapy Association

CDM—Chronic Disease Management

CPA—Chronic Pain Australia

DSM—Diagnostic and Statistical Manual

DVA—Department of Veteran Affairs

GP—General Practitioner

GPMP—General Practitioner Management Plan

MBS—Medicare Benefits Schedule

NDIS—National Disability Insurance Scheme

NPP—New Policy Proposal

PHN—Primary Health Networks

PNA—Practice Nurses Association

QALYs—Quality adjusted life years

RACGP—Royal Australian College of General Practitioners

TCA—Team Care Arrangement

1. Policy proposal

Changing the way that chronic pain is perceived and treated in the health system by enhancing the scope and coverage of Chronic Disease Management (CDM) services—with a special focus on women.

1.1 Policy scope

The new policy proposal (NPP) seeks to enhance existing Medicare-subsidised CDM services through: (i) a change in scope, coverage and eligibility for CDM services; and (ii) the development and delivery of specialist chronic pain education and training for health professionals in the primary care setting.

The NPP is consistent with the eight key goals[2] of the *National Strategic Action Plan for Pain Management*—namely that people in pain: (i) are a national health priority; (ii) are knowledgeable, empowered and supported consumers; and (iii) receive evidence-based care from skilled professionals.[3]

Further, the NPP is consistent with the current government policy agenda supporting: (i) a nationally co-ordinated effort to address the effective care and management for people living with chronic pain[4]; and (ii) health workforce enhancements[5] to support all health and care professionals to work to the full scope of their respective professions.

Chronic pain is defined as regular pain that lasts longer than three months and occurs for a variety of reasons including an injury, surgery, arthritis or other medical conditions such as cancer, endometriosis or migraines or it can be a condition in its own right.[6] The NPP seeks to enhance the perception and treatment of chronic pain not only associated with chronic disease but, also with other medical conditions and, as a condition in its own right.

---

[2] Goal 1—People living with pain are recognised as a national and public health priority; Goal 2— Consumers, their carers and the wider community are more empowered, knowledgeable and supported to understand and manage pain; Goal 3—Health practitioners are well-informed on best practice evidence-based assessment and care and supported to deliver this care; Goal 4—People living with pain have timely access to consumer-centred best practice pain management including self-management, early intervention strategies and interdisciplinary care and support; Goal 5—Outcomes in pain management are improved and evaluated on an ongoing basis to ensure consumer-centred pain services are provided that are best practice and keep pace with innovation ; Goal 6—Best practice pain knowledge is growing and is communicated to health practitioners and consumers through a national pain research strategy. ; Goal 7—Chronic pain is minimised through prevention and early intervention strategies ; and Goal 8—People living with pain are supported to participate in work, education and the community.

[3] Australian Government. (2021) *National Strategic Action Plan for Pain Management*, Department of Health and Aged Care.

[4] Australian Government. (2021) *The National Strategic Action Plan for Pain Management*, Department of Health and Aged Care, May (updated July 2021), <https://www.health.gov.au/resources/publications/the-national-strategic-action-plan-for-pain-management>.

[5] The Hon. Mark Butler MP (Minister for Health and Aged Care) Media Release: 'Unleashing the potential of our health workforce review – Appointment', 24 August 2023, <https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/unleashing-the-potential-for-our-health-workforce-review-appointment>.

[6] Painaustralia Factsheet—National Pain Week, <https://www.painaustralia.org.au/static/uploads/files/national-pain-week-3-wfsouyfpkuza.pdf>, accessed 7 August 2023; Painaustralia (2019). *The Cost of Pain in Australia*. Deloitte Access Economics.

1.2 Chronic Disease Management Services

CDM services are provided by General Practitioners (GPs) and are available to people with chronic or terminal medical conditions. As opposed to a specified list of eligible conditions, a GP can determine whether a patient would benefit from a structured approach to care, based on their clinical judgement and accounting for the eligibility criteria and guidance contained within the Medicare Benefits Schedule (MBS).[7]

CDM services cover the coordination, creation and review of three overarching care planning tools:

- A General Practitioner Management Plan (GPMP) (MBS items 721, 92024, 229)—a plan of action agreed between a patient and their GP. The plan identifies the patient's health and care needs, sets out the services to be provided by the GP, and lists the actions the patient can take to help manage their condition.
- Team Care Arrangements (TCA) (MBS items 723, 92025, 230)—for patients with complex care needs requiring multidisciplinary care, which provide Medicare-subsidised care (5 services per calendar year)[8] from selected allied health care providers[9] for individual treatment services where the patient also has a GPMP.
- Multidisciplinary Care Plans[10], are written plans that are prepared for a patient by a health or care provider including GPs often for patients in a Residential Aged Care Facility and describe the treatment and services to be provided to the patient by the collaborating providers (for example, MBS items 731 and 739).
- A key feature for TCAs requires GPs to collaborate and communicate with at least two other clinicians, health or care providers (for example, two allied providers or one allied and one pain specialist) who will provide ongoing treatment or services under the TCA to develop and finalise a respective TCA.

[7] Department of Health (2014) *Questions and Answers on the Chronic Disease Management (CDM)*, Department of Health, Australian Government.

[8] A Medicare rebate is available for a maximum of five individual allied health services per patient per calendar year. More services in a calendar year are not available under any circumstances. Each service must run for at least 20 minutes. The allied health provider will supply a report on their treatment to the referring GP or medical practitioner after a patient's first and last service, or more often if clinically necessary (Department of Health 2014).

[9] There are 13 eligible individual allied health services: Aboriginal and Torres Strait Islander health services; diabetes education services; audiology; exercise physiology; dietetics; mental health services; occupational therapy; physiotherapy; podiatry; chiropractic services; osteopathy; psychology; and speech pathology.

[10] MBS items 729, 231, 731, 232.

2. Policy purpose

Chronic pain is multifaceted and is a complex condition, and everyone experiences it differently. It is rooted in and influenced by biological, psychological and social factors (biopsychosocial), the treatment of which is unique to the needs of the individual. As pain can exist as part of, or due to, other conditions and comorbidities, such as fibromyalgia, musculoskeletal conditions or migraine, it is often overlooked and not addressed as a stand-alone condition. Chronic pain exists as a stand-alone diagnosis, sometimes long after the physical injury or illness has been resolved. Chronic pain is a diagnosis in and of itself and well-managed and well-treated chronic pain will lead to better physical and mental health outcomes.

Management and treatment processes must recognise the nature and complexity of pain. Chronic pain is considered to be 'one of the most difficult conditions to treat'.[11] Contributing factors for this include that it is challenging 'to assess the short-term and long-term effects of any particular treatment that you use. Pain is very individual'.[12]

While pain research over the last 30 years has generated various findings and developments in therapies for the treatment and management of pain—what has not changed is that, 'no one treatment works for every patient, even for pain of the same type and etiology. … *[T]*he meanings of pain—cognitive, affective, behavioural—are different for each individual and shape the pain experience and response to therapy.'[13]

> *For those who experience chronic pain, the pain can be debilitating and have an adverse effect on work, sleep, and relationships. Individuals with chronic pain may also commonly experience comorbidities such as depression, sleep disturbance and fatigue.*
>
> The National Strategic Action Plan for Pain Management (2019)

[11] Marcia Meldrum (associate researcher in the department of psychiatry and biobehavioral sciences at the University of California, Los Angeles) quoted in Collier, R. (2018) 'A short history of pain management', *CMAJ*, Jan 8, 190(1), pp. E26–E27.
[12] Ibid.
[13] Meldrum, M. (2003) 'A Capsule History of Pain Management', *JAMA*, 290:2470–2475, p. 2474.

3. Rationale

Many Australians living with pain have been unable to access high quality pain assessment and management, whether due to cost, geographic barriers, low awareness of treatment options, or lack of access to health professionals with the right knowledge and skills. The NPP would make an effective contribution to addressing these issues.

It is Painaustralia's view that the overarching gap in chronic pain management and treatment stems from insufficient systemic funding through the MBS to support multidisciplinary chronic pain management. Like all chronic conditions, chronic pain is best managed in the community, and evidence supports a multidisciplinary model of care that takes into account the physical, psychological, social and environmental factors that influence the experience of chronic pain.

Only those patients suffering with the most chronic cases need to be referred to pain management specialists. To ensure coordination of care for a referred patient there needs to be consistent and clear communication between the GP and the specialist pain physician. This is important for the development of a treatment plan to diagnose, treat and manage a patient suffering from pain and to ensure that all the needs of the patient are addressed.

3.1 Multidisciplinary chronic pain management

> *Doubling access to multidisciplinary care: this would cost $70 million a year but save the nation approximately $271 million.*
>
> Painaustralia Annual Report 2022–23

Pain research over the last 30 years supports the complexity of chronic pain and the need for pain management approaches to encompass multidisciplinary or integrated care models.[14]

Multidisciplinary pain management interventions have been found often to be superior to standard treatment of pharmaceutical and invasive care for chronic pain management.[15] In its current form, the MBS does not support this best-practice model, leading to unnecessary use of hospital-based services and more significantly, an historic over-reliance on medication including opioids. Data from the *Cost of Pain report* reveals that 68 per cent of pain management consultations will end with a GP prescribing pain medication only. Another 13 per cent will end in imaging, but less than 15 per cent can hope to be referred to an allied health professional.[16] This unfortunately means that for the 3.4 million people living with chronic pain, access to best practice care is challenging at best, and fatal at worst.

[14] National Academies of Sciences, Engineering, and Medicine. (2019) *The Role of Nonpharmacological Approaches to Pain Management: Proceedings of a Workshop,* Washington DC: The National Academies Press, p. 1.
[15] Painaustralia and Deloitte Access Economics. (2019) *The cost of pain in Australia*, Report commissioned by Painaustralia, pp. viii–ix.
[16] Painaustralia and Deloitte Access Economics. (2019) *The cost of pain in Australia*, Report commissioned by Painaustralia.

Understandably the physical, mental and emotional toll of chronic pain impacts every aspect of patients' lives, and nearly 1.45 million people in pain (or nearly 45 per cent of patients) also live with depression and anxiety.[17] Further, one in two people living with chronic pain have considered suicide[18], which in turn creates an immense further burden on their treating GP.

Importantly, historically, at the time when there was an over-reliance on medication including opioids to treat chronic pain there were no alternative treatments available to people. The NPP goes someway to offering an alternative treatment regime and framework for people suffering from chronic pain.

Doubling Australians' access to multidisciplinary care to treat chronic pain could be achieved with a $70 million per year investment. Greater access to multidisciplinary care could deliver $3.7 million in savings to the health system (net of intervention costs) while reducing absenteeism ($65 million) and improving wellbeing ($203 million in QALYs[19] gained). Overall, the benefit to cost ratio is estimated to be 4.9 to 1.[20]

There is consistent evidence that multidisciplinary care models are cost effective. Evidence-based research estimates a saving of $8,100 per patient, and savings of $356,288 per person over a patient's lifetime compared to conventional medical treatment.[21]

The Australia Government established a review of the MBS to examine how MBS items could be better aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Review Taskforce established an expert Pain Management Clinical Committee (the Committee). The Report of the Taskforce, *An MBS for the 21st Century—Recommendations, Learnings and Ideas for the Future*, made 1400 recommendations to Government which included several recommendations for changes to the MBS, in particular to promote multidisciplinary pain management.[22] A key recommendation in that regard was that the MBS should support high value care for chronic pain through the support of multidisciplinary[23] approaches including planning, monitoring and review through consultations, group pain management, and telehealth.

The NPP seeks to change the way that chronic pain is perceived and treated in the health system by enhancing the scope and coverage of the CDM framework using a multidisciplinary care model.

> *Only 1 out of 100 people living with chronic pain will receive multidisciplinary care.*
>
> Painaustralia Annual Report 2022–23

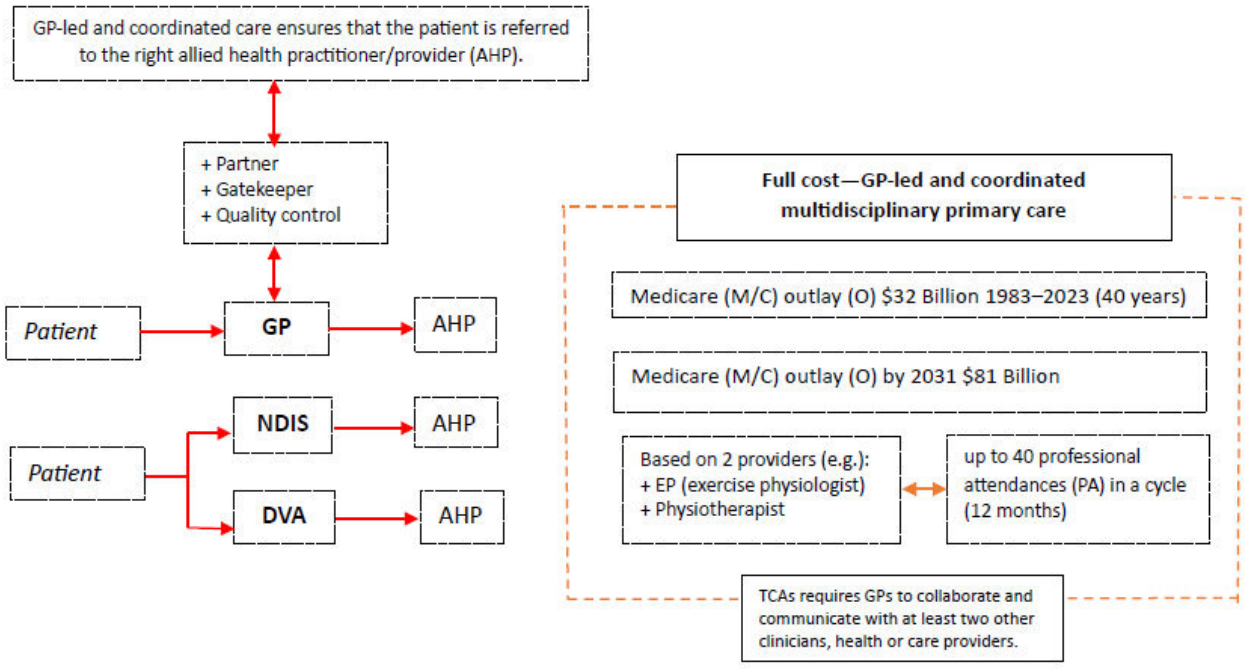
[17] Painaustralia and Deloitte Access Economics. (2019) *The cost of pain in Australia*, Report commissioned by Painaustralia.
[18] Refer Chronic Pain Australian National Survey 2023.
[19] QALYs—Quality adjusted life years.
[20] Painaustralia and Deloitte Access Economics. (2019) *The cost of pain in Australia*, Report commissioned by Painaustralia, p. 67.
[21] Ibid., pp. 67–68.
[22] Australian Government. (2020) *An MBS for the 21st Century—Recommendations, Learnings and Ideas for the Future,* Canberra.
[23] The five P's for multidisciplinary pain management are: physician; psychology; pharmacology; physical movement; and pacing.

3.2 Allied health services and chronic disease management

Allied health services and interventions are highly relevant for governments and policy makers seeking to address the burden of chronic disease. The cost and clinical effectiveness of allied health services and interventions, either as a supplement, and/or alternative, to medical or acute care interventions, in particular in the primary care setting is supported.[24]

Medicare subsidised CDM services enable GPs to plan and coordinate care for people with chronic disease or chronic conditions. The findings from evidence-based research for policy makers, funders and governments are clear about the effectiveness of primary health care interventions and multidisciplinary models of care. The findings indicate that funding models must support a framework to empower patients in their self-management and which is appropriately supported by GP-led and coordinated multidisciplinary teams in which allied health providers play a central role.[25] Figure 1—summarises the effectiveness of GP-led and coordinated multidisciplinary primary care interventions. It clearly shows the value of this type of framework for the treatment and management of chronic disease and conditions. The NPP seeks to enhance the scope and coverage of the CDM framework using a multidisciplinary care model.

Figure 1—Effectiveness of GP-led and coordinated multidisciplinary primary care interventions



[24]Allied Health Professions Australia. (2021) *Treasury Pre-budget submission 2021–22*, January; Smith, S.M., Soubhi, H., Fortin, M., Hudon, C., O'Dowd, T. (2012) 'Managing patients with multimorbidity: systematic review of interventions in primary care and community settings', *BMJ* 2012;345: e5205.

[25] Philip, K. (2015) 'Allied health: untapped potential in the Australian health system', *Australian Health Review* 39, p. 245.

Enhancing access to allied health services in the community or primary care setting 'can substantially reduce acute exacerbations of chronic and multimorbid conditions and their expensive impact on the acute health system. There is substantial evidence demonstrating the impact of allied health interventions (e.g. exercise, nutrition, good foot health and mental health) on the treatment of chronic disease…and hospital admissions'.[26]

As it concerns multimorbidity—two important points, supported by the literature, are emphasised: (i) persistent pain is associated strongly and consistently with almost all other common chronic health conditions, most strongly with mental health conditions, and the risk of persistent pain increases with every additional other health condition. While this relationship cannot be definitively described as causal (it is most likely a two-way relationship)[27]; and (ii) multimorbid patients prioritise the management of their chronic health conditions based on their functional impact. This means that poor management of high-impact conditions (for example, chronic pain) can lead to neglect of serious but low symptom conditions (such as diabetes, cardiovascular disease).[28]

Findings from evidence-based research for policy makers, funders and governments about the effectiveness of allied health interventions and multidisciplinary models of care indicates that 'relying on episodic medical intervention and acute hospital care, does not provide best practice or cost-effective management of chronic disease'. Importantly, it indicates that '*[t]*he locus of care needs to shift from acute to community, and focus on long-term management. The funding models must move to facilitate consumers in their self-management appropriately supported by *[GP-led and coordinated]* multidisciplinary teams in which allied health plays a key role'.[29]

[26] Philip, K. (2015) 'Allied health: untapped potential in the Australian health system', *Australian Health Review* 39, pp. 244–247; Smith, S.M., Soubhi, H., Fortin, M., Hudon, C., O'Dowd, T. (2012) 'Managing patients with multimorbidity: systematic review of interventions in primary care and community settings', *BMJ* 2012;345: e5205.

[27] Dominick, C.H., Blyth, F.M. & Nicholas, M.K. (2012) 'Unpacking the burden: Understanding the relationships between chronic pain and comorbidity in the general population', *PAIN*, 153, pp. 293–304; Australian Institute of Health and Welfare. (2020) *Chronic Pain in Australia*, Cat. no. PHE 267. Canberra: AIHW. ISBN 978-1-76054-669-4 (Online); Cabrera-León, A., Cantero-Braojos, M.A., Garcia-Fernandez, L., Guerra de Hoyos, J. A. (2018) 'Living with disabling chronic pain: results from a face-to-face cross-sectional population-based study', *BMJ*, Vol.8 (11), pp. e020913–e020913.

[28] Corbett, T. Cummings, A., Calman, L., Farrington, N., Fenerty, V., Foster, C., et al. (2020) 'Self-management in older people living with cancer and multi-morbidity: A systematic review and synthesis of qualitative studies', *Psycho-oncology*; Cheraghi-Sohi, S., Morden, A., Bower, P., Kennedy, A., Rogers, A., Richardson, J., et al. (2013) 'Exploring patient priorities among long-term conditions in multimorbidity: A qualitative secondary analysis', *SAGE Open Medicine*, (1); Gobeil-Lavoie, A-P., Chouinard, M-C., Danish, A., Hudon, C. (2019)' Characteristics of self-management among patients with complex health needs: a thematic analysis review', *BMJ Open*, 9(5); Morris, R.L., Sanders, C., Kennedy, A.P., Rogers, A. (2011) 'Shifting priorities in multimorbidity: a longitudinal qualitative study of patient's prioritization of multiple conditions', *Chronic Illness*, 7(2), pp. 147–161.

[29] Philip, K. (2015) 'Allied health: untapped potential in the Australian health system', *Australian Health Review* 39, p. 245.

4. Priority policy enhancements

In light of evidence-based research and findings; high level expert policy reviews; economic modelling, consumer, carers, health and medical practitioner experience and feedback; and public feedback—Painaustralia and its policy coalition allies have identified three overarching priority policy enhancements to help enhance the CDM framework and its services to provide better primary and pharmacy care for those Australians living with chronic pain and to minimise the social and economic burden of pain on individuals and the community.

The three overarching priority policy enhancements for the NPP to enhance existing Medicare-subsidised CDM services are:

4.1 Change in scope, coverage and eligibility for CDM services

The NPP recommends simple, small and low cost but highly effective changes to the scope, coverage and eligibility of services under the CDM framework; and how it articulates with other specialised GP Medicare services[30]—such as GP health assessments[31]; GP Mental Health services[32]; Diabetes cycles of care[33]; and Asthma cycles of care[34].

The recommended changes to the scope, coverage and eligibility of services under the CDM framework are:

- Support appropriate awareness and education initiatives to enhance the perception and treatment of chronic pain not only associated with chronic disease but, also with other medical conditions and, as a condition in its own right.
- The number of eligible individual allied health treatment subsidised services for multidisciplinary care under a TCA be increased from 5 services per calendar year to 10 services per calendar year.
- Those eligible consumers accessing CDM services be promoted to also have a current Mental Health Treatment Plan[35].
- Enhancing the scope of health workforce practitioners (with a focus on nurses, pharmacists and GPs) to work to the full scope of their respective professions.

[30] AIHW (2020) *Medicare-subsidised GP, allied health and specialist health care across local areas: 2013–14 to 2018–19*, AIHW, Australian Government, accessed 4 August 2023.
[31] GP health assessments—an assessment of a patient's health and physical, psychological and social function to identify opportunities for early intervention and care, for target population groups.
[32] GP Mental Health services—assessments, care planning and treatment for patients with mental health conditions.
[33] Diabetes cycles of care—services including specific checks and measures to encourage effective management of diabetes mellitus.
[34] Asthma cycles of care—services including specific checks and measures to encourage effective management of moderate to severe asthma.
[35] A Mental Health Treatment Plan (previously known as a 'mental health care plan') is a plan for people with a mental health disorder.

- Increasing the Medicare rebate for allied health care visits under a CDM Referral[36] so that it is equivalent to that for services delivered by allied health providers[37] under a Mental Health Treatment Plan.
- Local awareness, education and implementation of the proposed changes be supported by Primary Health Networks (PHN) in conjunction with allied health and other providers. The proposed changes to be introduced and funded for two budget cycles with funding for the budget outyears reliant on an appropriate evaluation.

4.2 Promoting health professionals authorised and qualified to complete GPMPs and TCAs

To address the needs of GPs pressed for time and/or GP practices with limited resources—the NPP seeks to enhance the utilisation of nursing professionals within the GP practice setting and also via telehealth platforms to support the preparation of GPMP and/or TCA items. The National peak nursing training body—the Australian College of Nursing (NCA) and the Practice Nurses Association has signalled their support for this proposal. Further, the NCA has indicated its willingness to work with Painaustralia to develop a unit of qualification for nurses to be trained in pain management to comprehensively support expanding the role of health professionals authorised to complete high quality GPMPs and TCAs.

Additionally, the added benefit of activating a new cohort of practitioners as part of CDM services provides opportunities to add new supply to the workforce, for example, nurses who may prefer to work from home; work online; or part time in a GP practice and who are currently not in the workforce due to lack of flexibility.

4.3 Development and delivery of specialist chronic pain education and training

> *Around one-fifth of all GP presentations in Australia involve chronic pain.*
>
> Painaustralia Annual Report 2022–23

The most common entry points for consumers affected by persistent and chronic pain are through contact with their respective GP or pharmacist.

The NPP recommends specialist chronic pain education and training for health professionals in the primary care setting. Development of specialist pain management modules for health and medical practitioners for delivery through the respective Royal Australian College of General Practitioners; the Australian Medical Association; Australian College of Nursing; Practice Nurses Association and the Pharmacy Guild of Australia.

[36] The current Medicare rebate for allied health care visits under a Chronic Disease Management Referral is usually $58 per session (or if a patient has exceeded the Medicare safety net for the year, it may be rebated at a higher rate). (Refer MBS Online).

[37] The current Medicare rebate for services delivered by allied providers under a Mental Health Treatment Plan is usually $92.90 (Refer MBS Online).

Appropriate advanced pain management training can help GPs, pharmacists and other health professionals to further develop and improve their skills in diagnosing, treating and referring patients with chronic pain to appropriate services; and participants would be accredited in chronic pain management as determined by the relevant colleges or professional bodies. This will also expand professional scope of practice and decision making for respective health and medical professionals.

> *The roll-out of a pain specialist designed and led national GP training program: this would cost $45 million but save $209 million in overdose-related costs.*
>
> Painaustralia Annual Report 2022–23

5. Recommendations

Painaustralia and its policy coalition allies calls on the Federal Government to commit funding to the following proposals in the 2024–25 Federal Budget:

- **Support the use of the Medicare Benefits Schedule Chronic Disease Management Framework to treat and manage chronic pain not only associated with chronic disease but, also with other medical conditions and, as a condition in its own right. It is acknowledged that this use would be consistent with the diagnostic classification system (symptoms and criteria) for defining 'predominant pain' in the Diagnostic and Statistical Manual of Mental Disorders (DSM).**[38]
- **Fund an expansion of the Medicare Benefits Schedule Chronic Disease Management Framework—with an increase in individual allied health treatment subsidised services for multidisciplinary care under a Team Care Arrangement.**
- **Enhance the Medicare Benefits Schedule Chronic Disease Management Framework for eligible individual allied health treatment subsidised services for multidisciplinary care under a Team Care Arrangement by not limiting services to two allied-health providers with usage to be more bespoke and determined as needed by the patient and their General Practitioner.**
- **Increase the Medicare rebate for allied health care visits under a Chronic Disease Management Referral so that it is equivalent to that for services provided for focussed psychological strategies under a Mental Health Treatment Plan.**
- **The proposed changes to the Medicare Benefits Schedule Chronic Disease Management Framework be subject to an independent assessment and evaluation for an initial period of two budget cycles.**
- **Expand the scope of health professionals authorised to complete General Practitioner Management Plans (GPMP) and Team Care Arrangements (TCA)—with a focus on nursing professionals within the GP practice setting and also via telehealth platforms to support the preparation of GPMP and/or TCA items.**
- **Support the development and delivery of specialist chronic pain education and training for health professionals in the primary care setting.**

[38] The Diagnostic and Statistical Manual of Mental Disorders (DSM) is published by the American Psychiatric Association and covers all categories of mental disorders for both adults and children. The DSM-5-TR was released in 2022 and is current edition.

6. Net cost/resource requirements

> *Chronic pain is estimated to be Australia's third most costly health condition in terms of health expenditure, noting musculoskeletal conditions are the second most costly, and injuries the fourth (both carry a strong association with chronic pain)*.
>
> Access Economics (2007) The high price of pain: The economic impact of persistent pain in Australia

6.1 Enhancement of the CDM Framework

It is proposed that the net cost/resource requirements would be accommodated within the broader MBS budget, with offsetting savings accruing from reductions in unnecessary health care presentations and inappropriate use of opioids.

The enhancement of the CDM Framework as detailed in the NPP to support multidisciplinary chronic pain management, planning, education and review will lead to better access to a broader range of services, including allied health care, and reduced dependence on pharmaceutical management of pain, improving physical and mental health outcomes for people living with pain.

> **Pain carries a significant economic cost**
>
> *The Cost of Pain report has pulled data out of the health, aging and disability sectors, to reveal the staggering cost of chronic pain to taxpayers. In 2018, this figure was $139.3 billion. This was on top of the fact that last year alone, Australians paid $2.7 billion in out of pocket expenses to manage their pain, with costs to the health system in excess of $12 billion*.
>
> Deloitte Access Economics (2019) Cost of Pain in Australia

In the context of the CDM Framework, a report by the Australian Institute of Health and Welfare (AIHW) examining the use of CDM and allied health Medicare services found that in '2019, close to $1 billion was paid by Medicare for CDM services'.[39] According to the AIHW, this represents a rate of $39,414 per 1,000 population. Of this, GPMPs had the highest overall costs ($420 million), followed by a Review of GPMPs or TCAs ($286 million) and Coordination of TCAs ($283 million).[40]

[39] Australian Institute of Health and Welfare (2022) *Use of chronic disease management and allied health Medicare services*, AIHW, Australian Government, accessed 4 August 2023.
[40] Ibid.

6.2 The cost of pain in Australia

As to the cost of pain in Australia and why reforms as proposed in the NPP are needed, it is important to consider the figures for Australians affected now and into the future. In 2018, chronic pain affected 3.24 million Australians—of whom 53.8 per cent were women and 68.3 per cent were of working age.[41] As to the future—it is estimated that by 2050, the prevalence of chronic pain will increase to 5.23 million (16.9 per cent)—with the chronic pain of 2.95 million of those Australians 'expected to limit the activities they can undertake.'[42]

Painaustralia is of the view that cost assessment processes for CDM must consider the complexity of pain. To effectively do this, cost assessments must adopt societal cost based perspectives that include evaluation of: (i) direct costs and outcomes—including direct costs borne by the health care system (for example, drug costs, costs of hospitalisation) and direct outcomes (quality of life impact) on the patient; and (ii) indirect costs, outcomes and effects—including productivity loss of patients due to illness and gains due to participation in the workforce due treatment interventions; and indirect outcomes (quality of life impact) on those affected by caring for an ill patient (for example, carers, parents).[43]

It is clear from the data as to the cost of pain in Australia and the figures for Australians affected now and into the future—that the cost of the reforms proposed in the NPP are already being paid for by the health system and society as a whole. The net cost/resource requirements for the NPP would be accommodated within the broader MBS budget, with offsetting savings accruing from reductions in unnecessary health care presentations, inappropriate use of opioids, productivity gains, and importantly through the strengthening and enhancement of multidisciplinary pain management in the primary care setting. For example, the roll-out of a pain specialist designed and led national GP training program, would cost $45 million but save $209 million in overdose-related costs.[44]

The Cost of Pain in 2020

- *$22,500 per person a year;*
- *$12.64 billion health system costs;*
- *$49.74 billion lost in productivity;*
- *$13.09 billion other financial costs; and*
- *$68.63 billion reduction in quality of life.*

If no action is taken, the annual cost of chronic pain in Australia will rise from $144.10 billion in 2020 to an estimated $215.6 billion by 2050.

Painaustralia Annual Report 2022–23

[41] Painaustralia and Deloitte Access Economics. (2019) *The cost of pain in Australia*, Report commissioned by Painaustralia, p. 18.
[42] Ibid.
[43] Hanley, R., Manton, A. and Trace-MacLaren, K. (2019) *The Value of Vaccines Ensuring Australia keeps pace with community values and international practice*, GlaxoSmithKline Australia Pty Ltd and Hears Pty Ltd, accessed 28 May 2023, p. 20 <gsk-value-of-vaccines-advance-copy.pdf>; GlaxoSmithKline Australia and ViiV Healthcare. (2018) *The Pharmaceutical Benefits Scheme in Australia—An explainer on system components*, February, report prepared by GlaxoSmithKline Australia Pty Ltd and ViiV Healthcare Pty Ltd with the assistance of Deloitte Access Economics Pty Ltd, accessed 28 May 2023, <https://au.gsk.com/media/6259/gsk-viiv-the-pbs-in-australia-feb-2018.pdf>.
[44] Refer: Painaustralia Annual Report 2022–23 and Painaustralia and Deloitte Access Economics. (2019) *The cost of pain in Australia*, Report commissioned by Painaustralia, p. 67.

6.3 Women and chronic pain

Further, it is also clear from the data that the most common person in Australia living with chronic pain is a woman in the peak of her working years. The NPP is focused on changing the way that chronic pain is perceived and treated in the health system by enhancing the scope and coverage of CDM services—with a special focus on women.

Currently only 1 out of 100 people living with chronic pain receive multidisciplinary care. It is a matter of justice, in particular for the women of Australia that the systems for multidisciplinary pain management meet the needs of those Australians suffering with chronic pain.

The NPP seeks to: (i) strengthen multidisciplinary care at the GP level and the information presented to pain consumers in pharmacies, to empower those suffering with chronic pain to take strides forward in their care; and (ii) make multidisciplinary pain care accessible to every Australian who needs it and especially to every woman living with chronic pain, via GPs and supported by pharmacies.

Lead policy contact

Mrs Giulia Jones
Chief Executive Officer
Painaustralia
Email: g.jones@painaustalia.org.au
Phone: (02) 6232 5588 or 0439 958 298