AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
ABN 82 055 042 852

FACULTY OF PAIN MEDICINE

RESPONSE TO ROMSAC QUESTIONS OF 20 SEPTEMBER 2004

1. ***Cost the operation (and establishment) of an accredited multidisciplinary pain centre (MPC). The AMC Secretariat had received helpful information from the University of Sydney, Department of Anaesthesia and Pain Management Royal North Shore Hospital on the costs of the MPC, but the Committee noted that the operations and funding of this centre are complex and probably atypical. Costings based on one or two relatively straightforward/ typical MPCs would be appreciated. The Committee is seeking a broad breakdown of costs: capital costs, salaries etc.***

Establishment costs for MPCs can vary a great deal, depending on whether the project is greenfields or the extent to which existing facilities (and personnel) can be redeployed. Furthermore, financial data on establishment costs are difficult to interpret as there are so many different financing techniques used in the public sector (leases and the like) which can mask the call on capital and recast capital costs into recurrent costs. Therefore, the Faculty does not consider that it is in a position to offer any meaningful data in this area.

We would make the general comments that relative to many medical and surgical specialties, pain medicine is not at the capital intensive end of the spectrum and indeed that the cost of establishing a new MPC can be seen to be considerably less than that for establishing a new Day Surgery Unit, Intensive Care Unit or Radiotherapy Unit.

The Faculty has obtained data on operational costs from 3 MPCs, as are summarised in the following table:

Recurrent expenditure	**MPC 1**	**MPC 2**	**MPC 3**
Salary & VMO costs including on-costs Medical, Allied Health, Admin and nursing	$1,727,085	$859,000	$1,000,000
FTE	17	10.5	12
Drug, medical & surgical supplies	$324,264	$363,336	$386,000
Repairs & maintenance	$	$9,000	$
Other	$	$100,000	$
Total	$2,051,349	$1,331,360	$1,386,000
Total labour costs as a percentage of the total	84%	64.5%	79%
Activity indicators			
Outpatient services	2342	5,300	3241
Same-day patients	687	750	1301
Overnight-stay patients	750		22
Average length of stay[1]	2.41		

[1] For overnight patients

2. How many pain patients do Fellows of the Faculty treat annually, and what is the cost of this treatment in Australia?

We estimate that the 148 Australian Fellows of the Faculty see 146,000 pain medicine patients per annum. This is based on survey data which indicate that the Fellows see, on average, some 22 pain medicine patients each week and have a clinical workload of 44.9 weeks a year (eg, excluding leave, CME, etc).

The survey results are, at this stage, preliminary and based on a response rate to date of 50% overall (with not every respondent answering every question). There may be some sampling and non-sampling errors in these estimates. That said, the respondents appear to be quite representative of the full membership. See Appendix 1: Preliminary Analysis Workforce Survey 2005

A couple of points may help the Committee to interpret these data:

- These figures are estimates of patient episodes of care. They include consultations both initial and follow up, acute and chronic, rather than the number of patients per se, as they almost certainly include multiple services to some of the chronic pain patients who are more likely to be receiving longer term care;
- The survey data indicate that only a relatively small number of the Fellows in the Faculty are currently working full-time in pain medicine. On average, the Fellows are working 4 to 5 sessions a week in pain medicine (approximately half time).

3. If pain medicine were recognised as a medical specialty, what demand would there be for hospitals, which currently do not have an MPC, to establish same? How many new MPCs would be established, what would they cost to establish, and how many patients would they treat? The Faculty's earlier response is noted, namely that the optimum number of MPCs and pain medicine specialists is unknown, but an initial reasonable goal would be for one MPC per million population, with a wide geographical and 'model' distribution is desirable.

In the opinion of the Faculty, no strong correlation is expected between the recognition of pain medicine as a specialty and a demand from hospitals to establish MPCs. The Faculty believes that pain medicine delivers positive results for patients and, in the longer run, results in more cost-effective health care and a lower demand for overnight hospital stays. The recognition of pain medicine as a specialty may facilitate an increased profile. As ultimately patient outcomes are the most telling criteria, two main voices could be heard: increased public dissatisfaction with the facilities available to help patients with pain; and the realisation by a hospital or other health care facility that its management of patients with pain was suboptimal and needed to be improved.

The evolution of Emergency departments, Intensive care units, Recovery rooms, Day surgery and Endoscopy units has been such that they are now accepted as standard components of the function of major hospitals. Recognition of the role of Pain Medicine as a

discipline may lead to Pain Services also becoming accepted as standard in such institutions but, as argued above, much less capital-intensive and expensive.

An MPC is but one of the settings from which effective pain medicine can be delivered. From the viewpoint of the Faculty, an MPC can be a very effective way to deploy the human and medical facility resources that are used in pain medicine. As noted in our reply to question 1, establishment costs are too variable to be usefully described. The number of MPCs is, ultimately, a matter for State governments, area health authorities and hospital managers.

The Faculty would argue that the issue of the management of pain in hospitals is one which could be a nationwide initiative in public health policy. We would reiterate, from Submission section 5.1, the promulgation in the United States in August 1999 by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) of its *Pain Assessment and Management Standards*. If the profile of pain medicine were raised in a similar way in Australia, it could reasonably be expected that all teaching hospitals and major regional hospitals will want to establish *identifiable multidisciplinary pain services*. (See also response to Q5 below.) This could be achieved through reorganisation of existing resources rather than necessarily increased allocation of funds, although the latter would be desirable. Not all hospitals or health care facilities need the same style or structure as a formal MPC. As was argued in Submission section 5.4, a goal of one MPC per million population would be reasonable but a more realisable goal may be a larger number of viable multidisciplinary community- or institution-based facilities.

The Faculty has provided some information on unmet demand for services which would indicate that there is a need for more services and therefore more facilities than seen currently. Specification of optimum resources is an academic exercise. We are well aware that pain medicine has to compete with other demands on finite human and financial resources

However there is a broader question to be addressed, namely if Pain Medicine were recognised as a medical specialty, what demand would there be for *community multidisciplinary pain services*, *staffed by physicians trained in Pain Medicine* to be established?

In considering this broader question, a third, potent influence would come into play. This is the reaction by those bodies which currently bear the annual $10B burden of the ineffective treatment of chronic pain, namely Federal and State Governments, Workers Compensation Authorities and other Insurers, to the greater efficiencies offered by Pain Medicine facilities.

In summary, recognition of Pain Medicine as a specialty is likely to enhance the wise use of available health care resources, through reorganisation and rationalisation of existing facilities and targeted development of new ones.

4. ***If recognition were provided, would the threshold for referral to a pain specialist change? The Committee notes the Faculty had argued that there was significant unmet demand for specialist pain services and had provided information on waiting lists to the review group to support this claim. A cross-sectional study to determine the extent to which specialist pain services are being provided by other specialists may be helpful. For example a hospital-based study to determine how many specialists would care for patients with pain because of limits on the pain medicine services available. The Committee notes the Faculty's statements that "****Patients are referred to a pain medicine specialist by other medical practitioners (general practitioners or specialists) when they form an opinion that the patient is beyond their own capacity to treat effectively, or when the patient requests such referral****", and***

further that ***"****Many hospitals are now very familiar with the operation of MPCs and specialist staff have developed a clear view of patients requiring referral****."***

There is no *prima facie* reason why the recognition of pain medicine as a specialty would alter the thresholds which GPs and other specialists might use when deciding whether or not to refer a patient to a pain medicine specialist. The waiting times that now pertain are likely to be a much more important influence on referral behaviour. A long waiting time may produce unacceptable standards of care and prompt a search for other solutions.

The 2002 ANZCA Workforce Survey classified respondents by area of interest. The respondents included 273 anaesthetists with some pain-related practice, whose activity levels were, on average, well below those of the Faculty members. Of these 273, 199 are based in Australia, 40 in New Zealand and the balance widespread. Inferring from the overall response rate (56%), there could be of the order of 350 Anaesthetists with activities in the area of acute and chronic pain. This compares with about 90 Australian Anaesthetist Fellows of the Faculty. Similarly, there will be doctors working in pain medicine who are neither Fellows of the Faculty nor Anaesthetists. In summary, there is quite a substantial number of medical practitioners who have some pain medicine activities but who are not Fellows of the Faculty. However, their self-reported activity levels are quite low. This may help throw some light on the total size of the medical workforce in pain medicine.

In addition to the data on waiting times previously supplied, it is also of some interest that the 2002 ANZCA Workforce Survey sought views of the respondents on workload. Of the 273 respondents with some pain related practice:

- almost 60% described their workloads as "about right";
- almost 40% would like less work or much less work; while
- only a tiny handful would like more work or much more work.

Again, another question is prompted by this one, namely what change in behaviour by other medical practitioners might be prompted by recognition of Pain Medicine? The knowledge that Pain Medicine exists as a specialty may well lead to increased demand for services from pain specialists in all modes of practice in the first instance. Through clinical feedback from Fellows, formal education and continuing professional development programs led by Fellows, an increased standard of care of pain patients by general practitioners and other specialists may then tend to reduce referral to the larger MPCs, with reduction in waiting times and therefore attenuation of misery and loss. The expected increased effectiveness of multidisciplinary pain management across acute, persistent non-cancer and cancer pain, in inpatient, hospital outpatient and community-based settings, will lead not only to increased efficiency of provision of service but also to enhanced perceived efficacy of that approach in the wider therapeutic community.

The Faculty argues that referral of complex cases to pain specialists would result in substitution of more efficient concurrent management plans rather than addition to current inefficient sequential plans. This would be another example of the wise use of available health care resources.

5. Model the optimal number of pain specialists required per 100 hospital beds.

The Faculty notes that the vast majority of pain medicine consultations (and indeed procedures where relevant) is performed in an out-patient setting. In-patient beds are utilised only rarely: for complex situations which cannot be facilitated out of hospital or, less uncommonly, for overnight stays in the context of analgesic procedures. As such it is difficult

to gain any sensible contemporaneous measure of the current ratio of pain specialists per 100 dedicated pain beds. We are not sure that the question is intended to refer to dedicated pain medicine beds *per se* or to all beds. Either way, ratios of specialists to beds would not appear to be a useful measure.

If however this question asks, how many pain specialists would be required to service pain consultations for hospital inpatients, the answer must be that every health care facility should have a defined line of communication with at least one specialist with accredited expertise in pain management, especially of acute (including post-operative) pain.

6. Estimate the costs associated with training a pain specialist.

We are unable to unravel the economic costs of training a pain specialist. Training is provided *in situ* in the context of the delivery of services. In theory, one could use an "attributable shares" method for allocating the time of the trainer between training and clinical services but that would involve entirely arbitrary judgments.

In large part, post-graduate medical training is provided at no explicit charge by senior staff specialists and VMOs, as part of the duties they undertake for their remuneration. The identified financial costs of training represent only a small part of the true economic costs. Furthermore, hospitals gain considerable benefit from the work done by registrars employed on relatively low salaries, but these benefits are never quantified. It is entirely possible to argue that registrars fund their own training costs (fully or in large part) by working at low salaries and providing their labour as a *quid pro quo*.

The Faculty does not consider that it is able to offer informed comment on the cost of training a pain medicine specialist. It does, however, offer the following points for whatever they may be worth:

- Explicit costs met by trainees: Registration fee $950
  Annual fee $925
  Examination fee $1900
- Costs met by employing authority for service provision: approx $85,000 (plus on costs and overtime) for a senior registrar

7. What is the Faculty's projected increase in the number of multidisciplinary pain medicine programs accredited for training, and over what time? How many trainees can be accommodated per accredited program? It is noted that the Faculty's accreditation guidelines have been revised so that it is possible for multiple centres in combination to meet the requirements for training, thus increasing the number of centres potentially able to provide training. It is also noted that the Faculty has argued that, as a minimum, the number of training posts should be increased to 24.

The Faculty's prime concern is not with the number of MPCs accredited for training but with the quality of individual programs for trainees. The key constraints on most training programs are:

- The number and mix of senior staff members able to provide the training at the required standard; and

- An environment which provides sufficient workload so that trainees get the exposure they need to prepare them for the full range of conditions and situations they are likely to encounter.

The Faculty has recently modified its philosophy and terminology of accreditation, partly in response to the ongoing challenge of creating opportunities for multidisciplinary experience for trainees and partly in response to comments arising out of the AMC review (2002). The Faculty now accredits "units" which can offer infrastructure and clinical exposure for trainees and "programs" which are the training paths followed by individual trainees. It follows that a trainee's "program" may involve more than one "unit" and be tailored to the needs of that trainee.

This increase in flexibility in accrediting units should facilitate an increased number of trainees; the Faculty does not restrict the numbers of trainees. A larger unit may accommodate more than one trainee; the program of any one trainee may include time in a larger unit and time in a smaller one. The Faculty has only recently commenced processing applications for accreditation of new units and reaccreditation of existing units in accordance with these changes. This changeover process will take about 18 months, during which time trainees will not be disadvantaged.

The Faculty's suggestion of a need for 24 training positions is based on assessment of needs and current under-supply of services. (Victoria is particular seems to be short of both pain specialists and MPCs, although changes are on the way.) In short, the suggested training numbers reflect a patient-centred assessment of the workforce requirement, not a facility-centred assessment.

The Faculty believes that this evolution in terms of units and programs directly addresses the issue of wise use of available health care resources.

8. ***How does the Faculty envisage the practice of individual practitioners may develop if recognition were granted? In particular, further information regarding the development of pain medicine services in the private setting (and how this would relate to the multi-disciplinary approach emphasised in the application) would be helpful.***

The Faculty would enlarge on the argument in Response section A3.1.

There is no one model of pain medicine practice. The essence is its multidisciplinary nature, which translates into close liaison between skilled physicians from different backgrounds and with other health professionals where possible. Recognition would stamp this model of complex care with gravitas and approval. In the private setting, recognised Pain Specialists would triage pain patients towards physical and/or psychological modalities of treatment, whilst retaining investigative, diagnostic and pharmacotherapeutic responsibility and overall supervision. The Faculty envisages an increased demand for such services, especially from consumers if not from payers, and consequently an increased number of pain specialists to be trained to service this need. However it should be emphasised that meeting this need in the private setting is not synonymous with increased demand on the public purse. As has been described in the Submission, much private pain medicine work, especially in persistent non-cancer pain, occurs in third party payer situations. In the private hospital setting, the effect of recognised Pain Specialists is envisaged to translate into increased efficiency, especially with respect to elective procedures. In pursuit of this, the Faculty has recently given limited (2 year) accreditation to a private multidisciplinary facility for advanced training in Pain Medicine.

The Faculty believes that it is unlikely that recognition would lead to any significant change in the pattern in which multidisciplinary pain medicine is in fact practised. Processing any increased demand would be limited by consultation time available (noting the demanding nature of pain medicine practice), access to cognitive-behavioural expertise and access to day-hospital beds for procedures.

There are extant examples of multi-disciplinary care in private settings, for example, endocrinologists treating diabetes patients with the assistance of a paramedical workforce of nurses, dieticians, podiatrists and so forth. These are able to provide cost-effective care. There is no *prima facie* reason why multidisciplinary pain services cannot be delivered in a private setting; if anything, the market disciplines of the private sector increase the pressures on providers to ensure that they are efficient.

Pain medicine is like every other specialty in that it has to compete in a limited pool for its future workforce. To attract that workforce, a specialty has to be able to offer strong work satisfaction and interest, a satisfactory career path and competitive remuneration.

If resources are withdrawn from the public health sector, then it follows that an increasing share of the care will have to be provided in private settings. The issue then becomes one of a complementary financing framework.

The key point here is that hospitals can now establish MPCs (subject, of course, to budget constraints) while the funding for the private sector is organised in silos:

- medical Medicare for medical services;
- Medicare Plus for access to limited Allied Health funding provided through General Practitioners
- private health insurance for: private patient hospital care including pharmaceuticals in hospital; prosthetics; medical gap cover for in-patient medical services; and ancillaries covering some paramedical service costs; and
- PBS for pharmaceuticals (unless in a hospital setting).

There are some gaps in the private financing framework for the funding of some paramedical services. These would stand as some impediment to the private sector practitioner in pain medicine coordinating a multidisciplinary service.

Given the nature of the case-load of chronic illness, including persistent pain, in the community and the promise of effective multidisciplinary outpatient care for the more complex of these cases, a case can be made for recasting private financing structures so that they are more amenable to funding services such as pain medicine.

Addendum

On 11 October 2004 the World Health Organization (WHO) co-sponsored, with the International Association for the Study of Pain (IASP) and the European Federation of IASP Chapters (EFIC), the Global Day against Pain. The theme of that day was “Pain Relief as a Universal Human Right”. (See Appendix 2 and www.iasp-pain.org and www.efic.org)

WHO has recognised the importance of acute and chronic pain control integrated into the management of conditions such as cancer and HIV/AIDS. Arising out of the IASP/EFIC initiative last year, there is increased awareness by the WHO of the burdens of unrelieved acute pain and of persistent non-cancer pain. The initiative called for, among other things,

"…specialization (or subspecialization) in pain medicine, revision of training curricula of medical doctors and allied healthcare professionals to include more education on pain assessment and management [and to] establish practical treatment protocols or clinical paths to better pain management".

The initiative also stated: "Addressing the global burden on pain *need not involve costly high-tech interventions* but does require global education of health professionals, patients and their families to best apply *available, generally low-cost yet effective therapies*. Such efforts will be advanced by expanding the collaboration between interested international partners." (Emphasis added.)

It is in this context of a global movement towards pain relief as a human right that the Faculty of Pain Medicine submits that the discipline of pain medicine is well-placed to facilitate the delivery of enhanced outcomes within the present framework of health care resources in Australia and to help Australia play a leading international role in this area.

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