AUSTRALIAN
PAIN MANAGEMENT
ASSOCIATION

Australian Pain Management Association Inc. (APMA)

Submission to the

Standing Committee on Health Inquiry into

Chronic Disease Prevention and Management in Primary Health Care

July 2015

Who we are

The Australian Pain Management Association Inc. (APMA) is the national consumer health charity which advocates on behalf of the more than 3.2 million Australians from all walks of life estimated to be suffering from chronic (persistent) pain and supports individuals with chronic pain conditions, and their families across Australia.

The organization was established in 2009 in response to the need for evidence-based information and services for people living with chronic pain, and to provide a voice and community support. It has hundreds of members in all States and Territories of Australia, in metropolitan, regional and remote locations, with a wide variety of pain conditions and associated co-morbidities such as depression and obesity.

APMA works with governments, health administrators, clinician, research and community organisations (including state, national and international groups) to raise awareness of chronic pain and pain management, and to ameliorate the effects and consequences for people living with pain. APMA provides advice, advocacy and representations to governments, clinicians and health departments and administrators on behalf of people living with pain (see http://www.painmanagement.org.au/about_us/what-we-do-main-menu/assistance/advocacy.html).

Setting the scene – The extent of chronic pain across Australia

Chronic pain is a major health challenge for Australia. The management of pain in Australia remains shockingly inadequate, despite the efforts of health practitioners, consumer organizations and in recent years, State health authorities. One in five Australians will suffer persistent pain in their lifetime yet up to 80% living with this debilitating condition are missing out on treatment that could improve their health and quality of life. Access Economics in 2007 estimated that persistent pain costs the Australian economy $34 billion per annum, is Australia's third most costly health problem and as the population ages the numbers and costs are only increasing[1].

Despite these figures, persistent pain is still not recognized as a chronic condition for the purpose of action in response to the growing impact on the health of Australians and the health care system[2].

It has been estimated that less than 50% of patients with cancer pain receive effective relief, and similar levels of patients with acute pain fail to receive effective relief – despite the capability of current techniques to relieve more than 90% of this pain. Improved management of acute pain would reduce the subsequent development of chronic pain. It has also been estimated that less than 10% of patients with chronic pain receive effective relief – again, despite the capability of current techniques to relieve more than 80% of such patients, and such relief being capable of

[1] Access Economics Pty Ltd *The High Price of Pain: The economic impact of persistent pain in Australia* MBF Foundation November 2007
[2] National Health Priority Action Council *National Chronic Disease Strategy* Australian Government Department

reducing the worsening of conditions and symptomology[3].

There are a range of different categories of pain, including acute, chronic, neuropathic and cancer-related pain. Living with and managing persistent pain requires reliable and up-to-date medical treatment (including allied health and pharmaceutical assistance). It also needs self-management capability, utilising lifestyle information, activity and support. A combination of these measures can restore function and quality of life to individuals whose main disability is pain.

In Australia, approximately 19% of the population are currently affected by moderate to severe chronic pain. 33% of these sufferers had pain with high disability that was moderately to severely limiting. Overall, it has a considerable impact on quality of life, resulting in significant suffering and disability[4]. While in many cases it is accepted that a cure is unlikely, the impact on quality of life, mood and function can be greatly reduced by early and best practice measures.

As can be seen in Table 1 below, low back pain is ranked as the number one health burden in every age category apart from the 5-14 age group (where it is ranked number three) for disability-adjusted life years for burden of disease in Australasia[5]. It carries the highest ranking for "All ages". Neck pain also carries a high burden of disease, ranked number four in the combined 15-64 age category and number three across all age groups. Low back pain may be either acute or chronic but it is the chronic low back pain and neck pain which will increase the burden of disease, as the longer the conditions persist if not well managed. Low back pain is not a national health priority despite having a higher burden of disease than asthma, diabetes, Alzheimer's disease, ischemic heart disease, major depressive disorders and hearing loss.

Chronic pain not only has an impact on affected individuals and their families, it also has substantial economic costs. For example, health related expenditure on back pain alone was estimated to cost $1.2 billion (1.8% of disease related spending) in 2008-09[6]. The vast majority of patients with back problems will be managed in the primary care sector. It is critically important that general practitioners (GPs) and other healthcare professionals have the best possible resources and support to manage their patients properly and have different modes of access to appropriate specialist services when required. The number of patients requiring GP services has grown from 2.7 of every 100 GP-patient visits in 2003–04 to 2.9 in 2012–13[7]. A proportion of patients will require access to specialist secondary and tertiary care pain services. From 2003–04 to 2012–13, the hospitalisation rate (aged 45+) for back problems increased from 762 per 100,000 to 882 per 100,000.[8]

[3] National Pain Summit 2010 *National Pain Strategy; Pain management for all Australians*
[4] Australian Institute of Health and Welfare, Patient-based substudies from BEACH: abstracts and research tools 1999-2006, Prevalence and Management of Chronic Pain, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442456168
[5] Disability-adjusted life years is a composite of life lost due to premature death from the disease and years lived with illness or disability from the disease. The greater the disability-adjusted life years (DALYs), the greater the burden of disease.
[6] http://www.aihw.gov.au/back-problems/expenditure/
[7] http://www.aihw.gov.au/back-problems/treatment-by-gps/
[8] http://www.aihw.gov.au/back-problems/treatment-by-hospitals/

	Ages 5–14	Ages 15–49	Ages 50–69	Ages 70 +	All ages
1	Asthma	Low back pain	Low back pain	Low back pain	Low back pain
2	Major depressiv e disorder	Major depressive disorder	Other musculoskele tal	Alzheimer's disease	Major depressive disorder
3	Low back pain	Drug use disorders	Falls	Falls	Neck pain
4	Conduct disorder	Neck pain	Neck pain	COPD	Other musculoskele tal
5	Anxiety disorders	Anxiety disorders	Major depressive disorder	Other musculoskele tal	Falls
6	Iron-deficiency anemia	Migraine	COPD	Diabetes	Anxiety disorders
7	Neck pain	Other musculoskele tal	Diabetes	Other hearing loss	Asthma
8	Eczema	Asthma	Anxiety disorders	Ischemic heart disease	Migraine
9	Migraine	Alcohol use disorder	Osteo-arthritis	Neck pain	Drug use disorders
10	Thalasse mia	Falls	Migraine	Major depressive disorder	COPD

Table 1: Burden of disease, Australasia (nb. Includes Australia and New Zealand)[9]

Within Australia there is evidence of wide variation in clinical practice and resource provision across metropolitan areas, regional and rural Australia, with a widespread lack of knowledge about chronic pain and the management options that are available for long term back conditions and other chronic pain conditions.

A wide range of both pharmacological and non-pharmacological management strategies are necessary for chronic pain. In 2008-09 13.0% of all prescription pharmaceuticals ($153 million) was spent on low back pain, not including privately purchased over-the-counter medication. The amount patients spend on allied health treatment eg physiotherapy or accessing web based or other community resources has not been quantified as far as APMA can determine. The challenge is to understand the extensive published evidence for different treatments and to determine when and where to use them for the best long term outcomes for the patient. It is hoped that this inquiry will

[9]Information derived from AIHW http://www.aihw.gov.au/asthma/health-burden/

prompt the data collection and research required to improve clinical outcomes and quality of life for patients with chronic pain.

The National Pain Strategy – a plan for pain management services in Australia

Australia was the first country in the world to develop a national framework for the treatment and management of pain: the National Pain Strategy (NPS)[10]. Through the National Pain Strategy, a comprehensive and coordinated approach to health policy reform has been set out to prevent and manage this chronic disease.

The National Pain Strategy was the key outcome of the National Pain Summit held at Parliament House, Canberra, in March 2010. The Summit attracted 200 delegates representing more than 150 healthcare professional, consumer organisations, funders and not-for-profit bodies concerned with pain and treatment of pain.

The first draft of the NPS was developed by a series of Working Groups led by the Australian and New Zealand College of Anaesthetists - the Faculty of Pain Medicine (ANZCA/FPM), the Australian Pain Society (APS) and consumer groups, in collaboration with the MBF Foundation (now Bupa Foundation) and the University of Sydney Pain Management Research Institute.

The initial draft was further developed by a series of Reference Groups representing all primary healthcare disciplines, pain specialists, other relevant medical specialists and consumers. The subsequent draft, aligned with the recommendations of the Prescription Opioid Policy published by the Royal Australasian College of Physicians in April 2009, was released for public and stakeholder consultation in October 2009 and revised prior to the National Pain Summit.

[10] http://www.painaustralia.org.au/images/pain_australia/NPS/National%20Pain%20Strategy%202011.pdf

AUSTRALIAN PAIN MANAGEMENT ASSOCIATION

Inquiry Term of Reference 1: Examples of best practice in chronic disease prevention and management, both in Australia and internationally.

Example One: Pain Support Group managed in partnership by Eastern Health and APMA

Victorian Eastern Health delivers an ambulatory pain management service for people living with severe pain in outer-eastern Melbourne. As well it provides resources for GPs on pain management in adults and children.

The Knox Chronic Pain Support Group (KCPSG) is located at Lilydale and holds monthly meetings and provides social support at other times to participants who have completed one of the Eastern Health's pain management programs and who have been referred by the pain management service.

APMA supports the facilitators with training and resources for use within the KCPSG. The emphasis is on empowerment to self-manage chronic pain conditions, education and information on best practice self-care strategies and social interaction to ameliorate the effects of withdrawal and isolation because of chronic pain.

The KCPSG has been operating for eight years and over that time the chronic disease self-management groups initiated positive behavioural changes, and those lifestyle changes have influenced and improved the health of this chronic pain population. Similar pain support groups have also yielded beneficial impacts on important behaviour change for rural communities in the Latrobe Valley and Goulburn Valley, an underserved population with chronic conditions. These pain support groups also serve to support health consumers once they have finished a pain management program.

The Eastern Health provided pain management service has undertaken some early evaluation of the benefit of the pain support group.

Example Two: Health Trainers, Sheffield NHS, Northern England

Kirklees, Sheffield NHS in the northern part of England has various initiatives for people with chronic pain which link the medical treatment to positive health coaching and motivational approaches that the individual can take-up to improve their pain and overall wellbeing.

Kirklees Health Trainers

Once people are diagnosed with a chronic pain condition, Kirklees Health Trainers are on hand to help them learn to better manage their health. The health trainer is able to collaborate with the practice nurse and the patient with the long-term condition to set goals and improve health results.

Health trainers use motivational techniques to help patients identify health needs eg fatigue and tiredness issues. The trainers assess the health needs linked to pain, help each individual identify their key goals and priorities and work through health issues together to enable self-management. They support each individual to improve their skills in goal setting, pacing, staying healthy, managing setbacks and ways to soothe the distress of pain. They have a wide knowledge of community links,

support services and resources that can help sustain changes in confidence and skills to manage pain, thus improving self-efficacy and decreasing future health care usage.

Further information can be accessed at http://www.kirklees.gov.uk/community/careSupport/healthWellbeing/healthTrainers.aspx , and the Kirklees Health Trainer Service Evaluation 2012 can be found here. Sheffield Persistent Pain https://www.sheffieldpersistentpain.com/

Example Three: The Pain Management Plan, York, UK.

The Pain Plan is a self-paced pain management program developed by Professor Bob Lewin to provide cognitive behavioural therapy via a health coach and workbook to those patients who couldn't or wouldn't attend a group based pain management program in York, UK.

The Pain Plan was evaluated in a year-long study carried out in three multidisciplinary National Health Service (NHS) pain management centres. The trial showed that disability was significantly reduced and patients' ability to self-manage improved. A copy of the research report can be found here.

The second qualitative study gained patients' feedback. Some of the benefits that patients found included:

- Validation and support for the difficulty in living with pain
- Enhanced understanding of pain mechanisms and self-care strategies
- An ongoing resource for use after the end of the coaching programme
- Improved awareness of how mood, thoughts and beliefs alter the experience of pain
- Relaxation was highly valued
- Success with goals and motivation
- Learned pacing techniques
- High level of personal satisfaction
- Easy readability and high interest of the Pain Plan workbook

For further information view http://www.pain-management-plan.co.uk/

Inquiry Term of Reference 2: Opportunities for the Medicare payment system to reward and encourage best practice and quality improvement in chronic disease prevention and management.

Strengthen existing pain management services through better coordination

Over the last five years in particular there has been a growth in expertise in hospital based pain management services with the expertise delivering treatment to complex and difficult pain management cases. However, these services are expensive and are not incentivised or remunerated to build capacity amongst primary health care professionals.

Improved awareness of, communication between, and integration of these primary, community health and tertiary, services is a priority if they are to better meet the needs of people with chronic pain conditions.

Integrated care is the coordination, consistency and continuity of care over time and through the different stages of the person's condition.[11]

Pain management services should be developed and targeted so that patients receive the right care at the right time and in the local setting. Given the shortage of pain management specialists, Medicare could be rewarding multidisciplinary health care coordination between psychologists and physiotherapists or between psychologists and GPs, for example. This type of service delivery requires a partnership approach and greater communication and collaboration across all service providers and sectors.

Areas of action to optimise existing services through enhanced integration could include:

- Medicare remuneration for pain management plans developed by specialist tertiary, community health or primary health care professionals.
- Build on the Shared Care concept to enhance coordination by GPs and between GPs and specialist chronic pain teams and or pain medicine specialists by remunerating the professional time it takes to collaborate with other health professionals to better patient centred care.
- Facilitate access to an interdisciplinary team of pain health professionals in the community
- Promote access to best practice clinical practice guidelines, pain assessment tools and patient information resources.
- Enhancement of support for GPs, for example: Improved phone access to specialist support for GPs.

Strengthen existing pain management services through better access

People with chronic pain conditions often require access to multiple health providers eg. GPs, practice nurses, allied health, Aboriginal Health Workers and community supports.

[11] Department of Human Services. Primary Health Branch. 2008. Revised Chronic Disease Management Program Guidelines for Primary Care Partnerships and Primary Health Care Services.

Unable to find help other than surgical for chronic pain that is making life unbearable and life with no quality. Jenny.

Areas for Medicare to be strengthened include the ambulatory care and outpatient clinics in community based settings. This is timely given the development of the new enhanced community health centres which can be designed to improve models of care for people with chronic conditions.

Outreach workers and case management models for people with complex pain needs and those accessing services from various government agencies, particularly those not eligible for aged care support.

Enhanced access to equipment and aid services which may reduce the likelihood of flaring up the pain.

Inquiry Term of Reference 3: Opportunities for the Primary Health Networks to coordinate and support chronic disease prevention and management in primary health care.

Primary Health Networks will be best placed to commission projects and programs to meet areas of pain management need in their regions. This way existing health professionals and health promotion organizations will be able to deliver the services in their local communities; knowing the needs of the residents best.

In the past, Medicare Locals have competed with local health professionals and non-government organizations (including consumer health organisations such as APMA) to directly deliver (limited) services for pain management. Given they were paid for by the federal government they appeared to have a conflict of interest in providing the funding and applying it for it themselves to deliver these programs.

Primary Health Networks could build capacity in primary health care by facilitating education and training in pain management by specialist tertiary health care teams. This could also occur in collaboration with the Australian Pain Management Association so that community support is included in the health education.

Inquiry Term of Reference 4: The role of private health insurers in chronic disease prevention and management.

Fund and partner with community health organizations such as APMA to provide self-management education to consumers living with pain in Australia as well as designing and delivering consumer resources about chronic pain conditions and pain management.

Private health insurers could be funding APMA and other not-for-profits producing high quality and evidence-based patient pain management resources to continue producing and distributing these resources. This could also happen for pain self-management education programs.

Inquiry Term of Reference 5: The role of State and Territory Governments in chronic disease prevention and management.

Many people such as Emma have had major trauma resulting in a chronic pain condition:

I am 35 yrs old Female. My son and I were in a major car accident 6 yrs ago where we both had numerous injuries but my main problem is chronic pain in my right foot which was severed by the pedals in the accident but they managed to save it. I have constant pain and take morphine 4 times a day to be able to tolerate the pain. I am never pain free just different levels depending on the amount of pain medication i take. I would love to find another solution to my pain and stop taking the medication. Emma

If hospital specialists were required to develop pain management plans for people like Emma, and there were pain management education sessions existing in the local community, opioid medication of often diminishing efficacy would not be the only treatment option. As Emma identifies, she would love alternative therapies to be available. There is ample scientific evidence available for the efficacy of yoga and tai chi for example. These alternative therapies need to be provided on an ongoing basis so health consumers have the ability to access them based as required.

State and Territory Governments should have health promotion programs which could reduce the likelihood of chronic pain, such as staying as active as possible with acute back pain. However, their efforts are generally confined to delivering tertiary specialist pain management services once chronic pain is well established and has caused disability.

APMA has produced a range of brochures on chronic pain prevention, including:

- Do you have persistent pain?
- Getting **back** on track
- Nerve pain, it's hard to describe

State and Territory governments could distribute these information brochures to emergency departments, out-patients and community health centres to assist the prevention and worsening of chronic pain conditions.

Some States such as South Australia could provide pain management options in their GP Plus community health settings. These enhanced community health centres could develop models of care for patients in partnership with pain specialists.

State and Territory tertiary health facilities have a role to play in providing treatment to the most complex patients. Currently, public hospitals provide treatment and education to many people living with chronic pain who could have been treated in the primary health sector if the services existed.

In addition, they also have a role in building the capacity of pain management in primary health care by training primary health care professionals in pain management.

Expanded use of telehealth in the home for people with chronic conditions for example home monitoring, coaching, video consultation appointments and home medication management

Inquiry Term of Reference 6: Innovative models which incentivise access, quality and efficiency in chronic disease prevention and management.

APMA interventions using telephone and web-based technology

Since 2010 APMA has delivered the Pain Link helpline. The Pain Link is the only national helpline in Australia for people living with moderate to severe pain. It offers a lifeline to individuals distressed by living with persistent pain and its impacts. The service (from 7.00am – 7.00pm) provides callers with trained volunteers, who are able to listen, clarify issues, assist with action planning and provide options as needed to ameliorate the pain impacts causing the greatest personal distress to callers. Pain Link is one of the few ways that those in regional and rural areas or who are house bound can be supported by people who have become adept at managing their own pain and who have the skills to pass on this knowledge to others.

The Pain Link volunteers are able to deliver health coaching to callers using action planning to problem solve the issue causing the greatest distress. Callers are able to call back if they want this ongoing pain management process. It is quite a common situation for callers who have firstly, rung in distress, to later on, call back and talk to the Pain Link Guide about the personal gains they have achieved. 87% of callers are 'very satisfied' with the information and assistance they have received.

Public hospital based emergency departments, pain management services, Drug Arm and Lifeline refer health consumers to Pain Link as do many GPs. Currently, Pain Link takes 4-5 calls a day which is the limit of the service capacity.

Website

The APMA website www.painmanagement.org.au was established in 2009, and the quality and comprehensive nature of the website's content material is high. The site includes developments of interest not only to people living with pain and their families, but also health professionals and organisations working in the pain area. Content includes video and audio files, as well as written materials and a range of useful links.

In April 2015 APMA launched a new website which provides a fresh, crisper appearance with which to better engage consumers. The website is focussed on the biopsychosocial model of chronic pain and as such provides a whole suite of information to engage users in physical activity and other Peer support telephone support calls to improve health and managing chronic illness are often an

important element of community support. The Cochrane Review researched the results of peer support telephone calls on health. Several randomised controlled trials (RCT) from the Australia, Canada, UK and USA, associated with a range of conditions and target populations were included. Peer support telephone calls for post heart attack patients were associated with a change in diet in the intervention group of 54% at six months, reflecting some important health behaviour change occurring. [12]

Shortly, the website will also contain information on pain related dental health. This is an important topic which has the potential to significantly reduce the effects of 'dry mouth' and other pain related problems which lead to expensive and highly invasive dental procedures. This will be the only information of its kind on the World Wide Web for patients with chronic pain.

A Swedish study investigated the effects of an Internet intervention with telephone support for chronic back pain. Results demonstrated significant improvements in catastrophizing, control over pain and ability to decrease pain. These findings indicate that internet-based self-help with telephone support, based on established cognitive behaviour therapy is an effective approach for treating disability associated with pain.

Developing and testing internet resources to self-help has been investigated in studies on recurrent headache, tinnitus, panic disorder, post-traumatic stress, cancer, stress management, weight loss, paediatric encopresis, and eating disorders. The results from these studies are promising and indicate that the Internet is a cost-effective medium for providing services and that the improved patient outcomes are close to the effects of face-to-face treatment interventions.[13]

Mediums such as telephone and internet support are important and cost effective additions to GP care.

Facebook & other social media

The APMA Facebook site www.facebook.com/apma4u has been operated on a moderated basis since late 2011. The site has developed a large community of friends across the country (and internationally with more than 3,000 likes. The site enables large numbers of people living with pain to access latest evidence based news, videos and links as well as regularly communicating with each other.

[12] Dale J, Caramlau IO, Lindenmeyer A, Williams SM. Peer support telephone calls for improving health. Cochrane Database of Systematic Reviews 2008, Issue 4. Art. No.: CD006903. DOI: 10.1002/14651858.CD006903.pub2, http://www.cochrane.org/CD006903/COMMUN_peer-support-telephone-calls-to-improve-health-and-health-behaviours Accessed 20/4/15

[13] Controlled trial of Internet-based treatment with telephone support for chronic back pain Monica Buhrman, Sofia Faltenhag, Lars Strom, Gerhard Andersson, Pain 111 (2004) 368–377

Inquiry Term of Reference 7: Best practice of Multidisciplinary teams chronic disease management in primary health care and Hospitals.

The large multidisciplinary pain management centres in hospitals provide excellent pain management services. However, there is no effective chronic pain management model yet available in the primary health care setting. Although there is an occasional multidisciplinary pain management team existing, these don't yet have highly beneficial patient outcomes.

Inquiry Term of Reference 8: Models of chronic disease prevention and management in primary health care which improve outcomes for high end frequent users of medical and health services.

The COping with persistent Pain, Effectiveness Research into Self-management (COPERS)

This study commissioned by the UK National Institute of Health Research was a five year project to improve the self-management of chronic pain.

The overall objective was to develop and test a practical and effective self-management education for chronic pain. A group training package was designed, facilitated by a healthcare professional and a lay person with chronic pain with prior experience in small group facilitation. The course was delivered over four hours for three days with a two hour follow-up session two weeks later. All courses were held in a convenient, accessible location for participants.

The course used social learning theory and cognitive behaviour therapy and covered: understanding and accepting pain, mood and pain, unhelpful thoughts and behaviour, problem solving, goal setting, action planning, movement, relaxation and social integration/reactivation. Attendance was 85%.[14]

Health use analysis

At 12 months post course, they are conducting a cost-utility analysis measuring Quality Adjusted Life years (QALYs) from the NHS perspective. The costs include: primary care services, prescribed medication, investigations, intermediate care referrals and secondary care. Primary care services include consultations with GPs and practice nurses, both scheduled and unscheduled. Secondary care will include accident and emergency visits, outpatient appointments and inpatient episodes.

It is anticipated that the results will be available shortly.

[14] Pain management for chronic musculoskeletal conditions: the development of an evidence-based and theory-informed pain self-management course, Dawn Carnes, Kate Homer, Martin Underwood, Tamar Pincus, Anisur Rahman, Stephanie J C Taylor, BMJ Open 2013;3:e003534 doi:10.1136/bmjopen-2013-003534, http://bmjopen.bmj.com/content/3/11/e003534.full

It would be beneficial to trial this course in Australia, in the primary health care setting, partnering with the Australian Pain Management Association which could boost the course's ability to attract participants and to provide lay facilitators, experienced and skilled in small group facilitation.

Conclusions

The National Pain Strategy noted that:

> The 2009 National Health and Hospitals Reform Commission's recommendations for primary health care and chronic conditions could improve access to effective treatments for people with chronic pain, provided chronic pain is recognised as an eligible disease in itself, and health professionals are upskilled in pain management.
>
> Comprehensive primary health care centres, for example, could provide best-practice interdisciplinary and supportive care for people with chronic pain including medical care, physiotherapy, psychology, group education programs and medicines counselling. An advanced-skill or rural generalist GP trained in pain medicine and a pain educator could work in each comprehensive primary health care centre to start building capacity in the locale, working with other health professionals including pharmacists, complementary practitioners and specialists. The educator position could be connected to the proposed national health promotion and prevention agency and implement programs in early prevention of pain, prevention of progression, and workplace and community strategies for pain management. These positions could also coordinate an interdisciplinary clinical network for pain in the region. Importantly, this network could be linked into a specialist interdisciplinary pain clinic to underpin education, training, research, clinical development and quality assurance[15].

The Australian Pain Management Association strongly believes that the only affordable and sustainable strategy to address the growing burden of chronic diseases – including of course chronic pain – is to strengthen capacity in the primary (and community) levels of Australia's complex health system.

These services must be:

- Patient-centred and responsive to needs;
- Accessible, timely and affordable;
- Evidence-based;
- Empower consumers (patients), and
- Utilise peers and/or health consumer organisations in a partnership.

APMA (and many other health consumer organisation) have been making these observations over many years. We observed in 2010, in response to a discussion paper regarding the (then) proposed system of Medicare Locals,

[15] National Pain Strategy; Pain management for all Australians p. 9

> "People living with pain should be included as consumer representatives providing patient-centred input to all Medicare Local Networks. This can only be achieved if consumer health organizations (such as APMA) are properly resourced to be able to have real, accountable, involvement in Medicare Locals, rather than mere tokenistic positions giving the appearance rather than reality of meaningful involvement"; and
>
> "The provision of financial support to community organisations to enable them to provide on-going information and support to help people living with pain to deal with their condition and maintain effective self-management programs."[16]

We look forward to being heard – and supported…

[16] http://www.painmanagement.org.au/images/painman/APMA_submission_-_Medicare_Locals_November_2010.pdf