RACGP
Royal Australian College *of* General Practitioners

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09 June 2022

Health Technology Assessment Team
Department of Health
MDP Level 9 South
GPO Box 9848
Canberra ACT 2601

Via email: commentsMSAC@health.gov.au
pharmacy.trial.program@health.gov.au

Dear Health Technology Assessment Team,

Re: MSAC Application 1698 Chronic Pain MedsCheck Trial

The Royal Australian College of General Practitioners (RACGP) thanks the Department of Health (the Department) for the opportunity to respond to the Medical Services Advisory Committee (MSAC) Application 1698 Chronic Pain MedsCheck (CPMC) Trial.

The RACGP is Australia's largest professional general practice organisation, representing over 43,000 members working in or toward a career in general practice including four out of five general practitioners (GPs) in rural Australia.

GPs play a critical role in providing and coordinating care for people with chronic pain. An estimated 20–40% of patient presentations involve chronic pain, which makes it one of the most prevalent conditions managed in general practice.[1,2] Reports also indicate the number of people seeing GPs for chronic pain is rising, with patient encounters increasing by 67% over the past 10 years.[3] GPs provide lifestyle-based care, as well as refer to condition-specific specialist services and multidisciplinary colleagues in primary care.

The RACGP supports improving access to high-quality care for people living with chronic pain. However, we have serious concerns with the proposed CPMC model and its potential to shift chronic pain diagnosis and management away from medically trained professionals, leading to isolation and fragmentation of patient care. The RACGP also has multiple specific concerns regarding the trial and its findings (outlined on the next page).

Chronic pain is best managed through a medical specialist-led multidisciplinary approach

Chronic pain is a complex condition that can result from injury, surgery, musculoskeletal conditions such as arthritis, or other medical conditions such as cancer, migraines or endometriosis. Chronic pain can be difficult to diagnose and potentially present as a symptom of other conditions. Research is ongoing into the complexity of pain and its associations, with studies linking it to childhood sexual abuse, experiences of trauma and stressful life events.[4,5] People with chronic pain are also likely to experience mental health conditions such as depression and anxiety, sleep disturbance and fatigue.[6]

PainAustralia recommends people with chronic pain receive coordinated interdisciplinary assessment and management involving, at a minimum, physical, psychological, and social/environmental risk factors in each patient.[6] This type of assessment and management sits beyond the scope and training of pharmacists and should remain with medical specialist-led multidisciplinary teams.[7,8]

The CPMC model isolates chronic pain care under a single practitioner model. It does not provide opportunities for confidential discussions about the serious issues that can be associated with chronic pain, nor appropriate pathways to address these issues by more specialised medical professionals and services.

Ensuring ongoing management of chronic pain sits with an appropriately qualified medical professional is also particularly important given the risks of misuse associated with opioids, still commonly utilised as part of managing chronic pain, and the need to explore non-pharmacological interventions outside the scope of pharmacy.[9,10] Pharmacist involvement in chronic pain management should be focussed on medication management and quality use of medicines, and should be undertaken in close collaboration with a medical specialist under appropriate governance arrangements.

A multidisciplinary and evidence-based approach is also important to avoid potential financial interests in pharmacy and the impact this can have on care.[8] In the CPMC Trial, recommending non-pharmacological interventions would result in the pharmacist potentially missing out on additional income. This represents a clear conflict of interest for participating pharmacists. Given the importance of exploring non-pharmacological interventions for chronic pain, this is a significant and unresolved issue with the trialled CPMC model.

Isolated measures can fragment and duplicate care

The management of chronic pain often involves several medical practitioners and allied health professionals, which may cause some patients to feel confused and overwhelmed. Therefore, it is important to have one person who serves as the primary care doctor – someone who is familiar with the person's medical history and can coordinate the patient's overall medical care. The GP is ideally placed to take on this role and ensure care is continuous and coordinated.[11]

Continuity of care is linked to better patient–provider relationships, better uptake of preventive care, increased access to care, and reduced healthcare use and costs.[12,13] Research clearly shows the benefits of continuity of care in general practice, demonstrating association with fewer hospital admissions, which in turn generates health system savings and indicates good management of a person's health condition.[14,15]

Introducing short-term isolated measures in pharmacy has the potential to fragment and duplicate care. This can result in missed diagnoses, inappropriate prescribing, duplication of tests, missed opportunities for preventive care activities, poorer patient outcomes and increased costs for the health system.[16,17] Despite these potential risks, the CPMC Trial appears to incorporate no formal links back to general practice to ensure continuity of care, and minimal safeguards to prevent duplication of care. Even the referral parameters to a GP or emergency department are very unclear. Further, there is insufficient information available in the public trial summary to determine the full impact of the CPMC on continuity and coordination of care. Detailed investigation of these impacts is required prior to any continuation of the CPMC services.

Establishing isolated pathways to remunerate pharmacists under successive Community Pharmacy Agreements also raises concerns around whether these activities are captured through standard governance and regulatory processes, which are in place to ensure safety and quality of healthcare services. Any dispensing fee paid under these types of programs should include medication governance.

Limitations of the trial findings

The RACGP notes the following issues with the trial design and findings:

- Almost half (46.9%) of the participants did not finish the trial. The high drop-out rate could be reflective of poor recruitment and governance processes, inadequate quality of care and advice provided throughout the trial, and indicate that many participants did not find the program acceptable and useful. However, no

information is available to indicate why the drop-out rates were so high, despite it being a significant barrier to any broader rollout.

- Two-thirds of pharmacies (66.3%) that registered did not complete the trial. This may reflect poor recruitment and governance processes, limited demand for the trial services and that the proposed model was not acceptable or viable for pharmacies or pharmacists. No data seems to have been collected on this issue, despite it also being a significant barrier to any broader rollout.
- The Pharmacist Satisfaction Survey only had 43 responses. Given 1,630 pharmacies registered for the CPMC Trial, this is a response rate of less than 3%, and any findings from this survey cannot be considered reflective of the pharmacist experience of providing the CPMC service.
- The analysis of outcomes is only conducted on those participants that had a second face-to-face meeting. Statistical analysis should have been done on an intention-to-treat basis. This will likely have a large impact given the high drop-out rates.
- The trial had no formal control group, which limits the interpretation of the findings and means no conclusions about effectiveness can be made. Further, the trial made no effort to identify interventions that were instigated in primary care for the participants selected at the point in their lives where they were having self-management or dependency issues. It is likely that these patients would receive interventions such as alcohol and other drug counselling, pain management review and non-drug interventions. With the lack of a control group, it is not possible to solely attribute changes in outcome measures to the pharmacist intervention.
- The CPMC Trial fails to identify regression to the mean. Participants were picked by the pharmacist from those having self-management or dependency issues at the time of enrolment. We know these issues vary over time so it is anticipated that mean scores for the various outcome measures would naturally improve.
- The findings of the study do not seem to indicate significant benefits for participating patients. For example, there was no change in the average daily morphine equivalent dose in Group A or Group B participants from initial to follow-up. Further, the Consumer Impact Survey (CIS) results state that "…around a fifth reported noticing a definite improvement". This is a very low proportion of participants, indicating the intervention may not have benefited four out of five participants.
- The CIS summary also provides no detail on any constructive or negative feedback on the trial. It is important this feedback is available for the scrutiny of MSAC and other key stakeholders.
- The three-month follow up data is not long enough to determine the medium- to long-term impact on patient outcomes. Data collection at six months and 12 months at a minimum is required to determine if the outcomes of the trial were lasting and if there were any unintended consequences.
- The exclusion/inclusion criteria for participants does not appear to exclude patients who may have complex multimorbidity that would influence the trial results and indicate they require more complex care (eg people with severe mental illness).

These issues draw into question the proposed outcomes and cost-effectiveness of the CPMC Trial and clearly show there is insufficient evidence to support a broader rollout.

A better approach - Pharmacists in general practice

The RACGP notes many of the trials funded under the Community Pharmacy Agreements, including the CPMC Trial, are implemented largely in isolation from general practice and other important primary care services. These trials represent a missed opportunity to support pharmacists to provide high-quality medication services in close alignment and collaboration with their local general practice, which has the potential to significantly improve patient outcomes.[18]

The RACGP thanks MSAC for the opportunity to provide this feedback. If you have any queries regarding this submission, please contact Michelle Gonsalvez, National Manager, Policy and Advocacy on (03) 8699 0490 or via Michelle.Gonsalvez@racgp.org.au.

Yours sincerely

Adj. Professor Karen Price
President

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