Chronic pain and disability

A public health and co-ordinated care challenge

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Overview of talk

- recent evidence that helps define chronic pain as both a condition in its own right, and as a significant public health problem
- a population-focussed approach to managing the burden of chronic pain
- barriers to progress

Pain 137 (2008) 7–15

PAIN

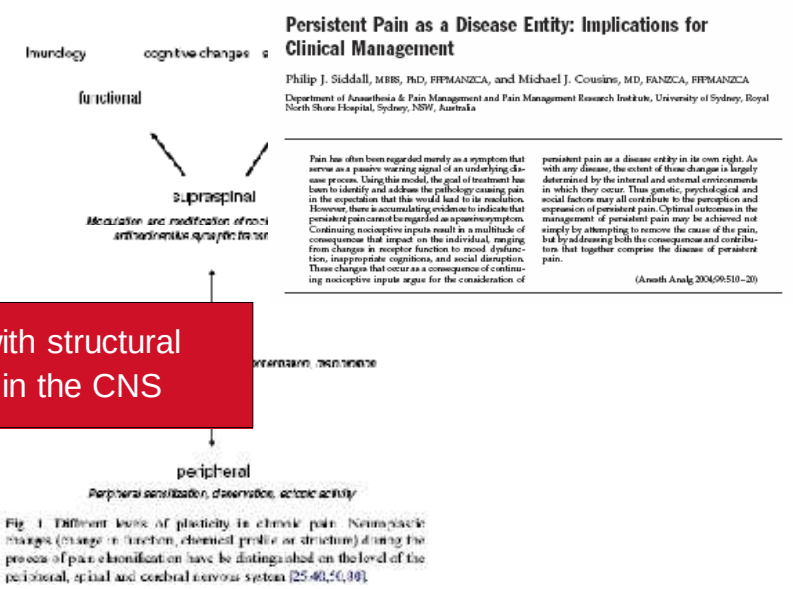
www.elsevier.com/locate/pain

Review

Chronic pain may change the structure of the brain

Arne May *

Department of Systems Neuroscience, University of Hamburg Eppendorf (UKE), Martinistrasse 52, D-20246 Hamburg, Germany



Chronicity is associated with structural and functional changes in the CNS

How can pain epidemiology help? - the Australian experience

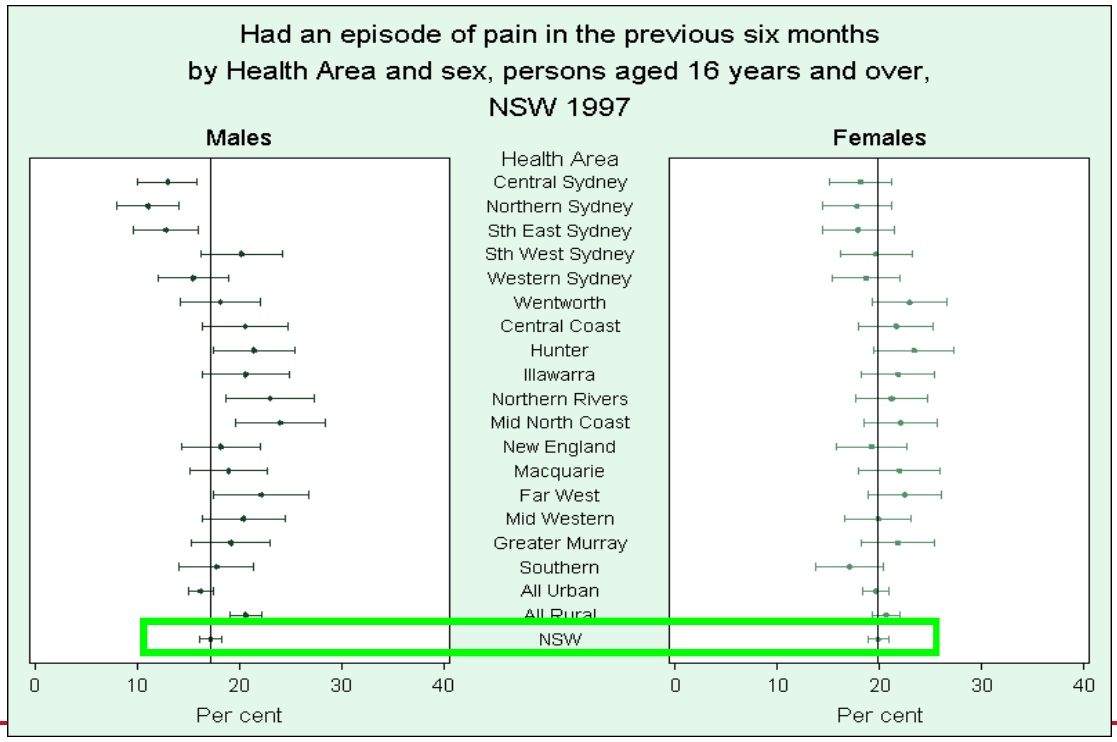
Acute and chronic pain service funding

Economic impact of chronic pain

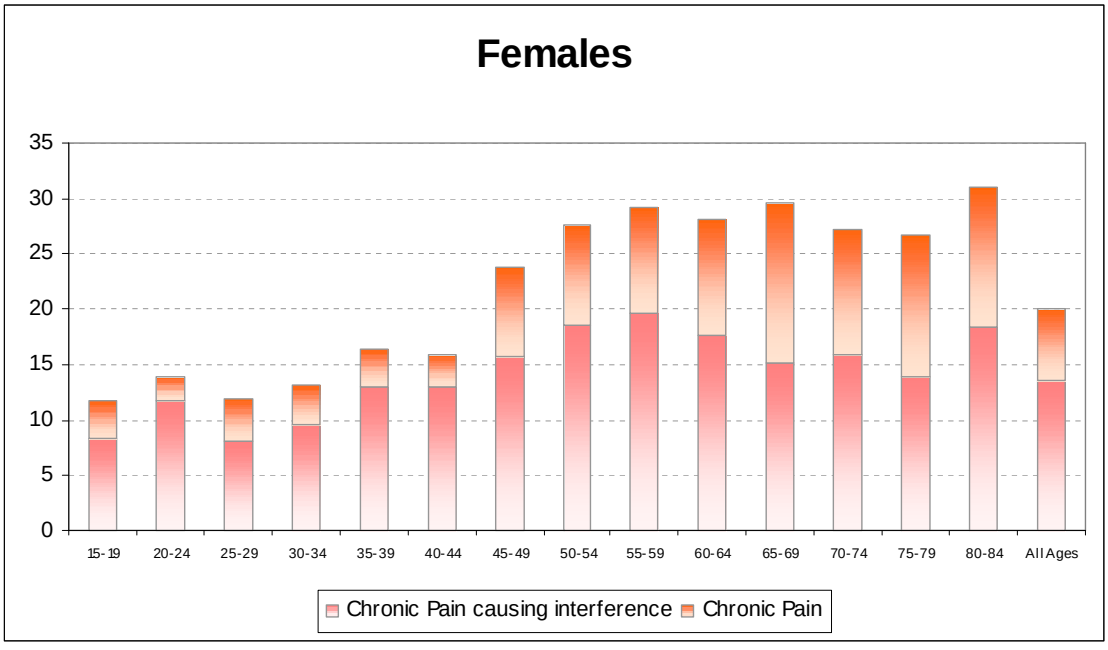
Australasian Faculty of Pain Medicine

Advocacy/support

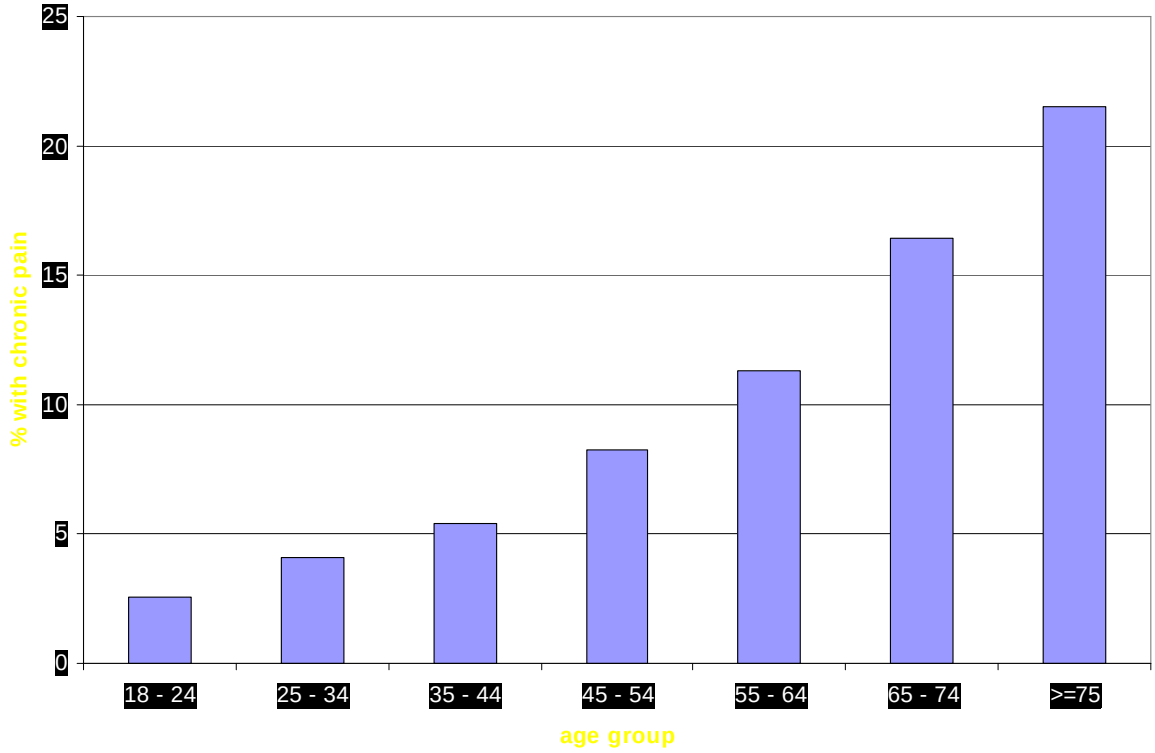
Putting the population back into pain research



NSW Health Survey - prevalence of chronic pain and pain-related disability, females *(Blyth et al, Pain 2001)*



Malaysian National Health Survey 2006



ACCESS ECONOMICS

mbf foundation
Building a healthier community

The high price of pain: the economic impact of persistent pain in Australia

November 2007

Report by Access Economics Pty Limited for

MBF Foundation
in collaboration with
University of Sydney Pain Management Research Institute

Costs of pain in Australia

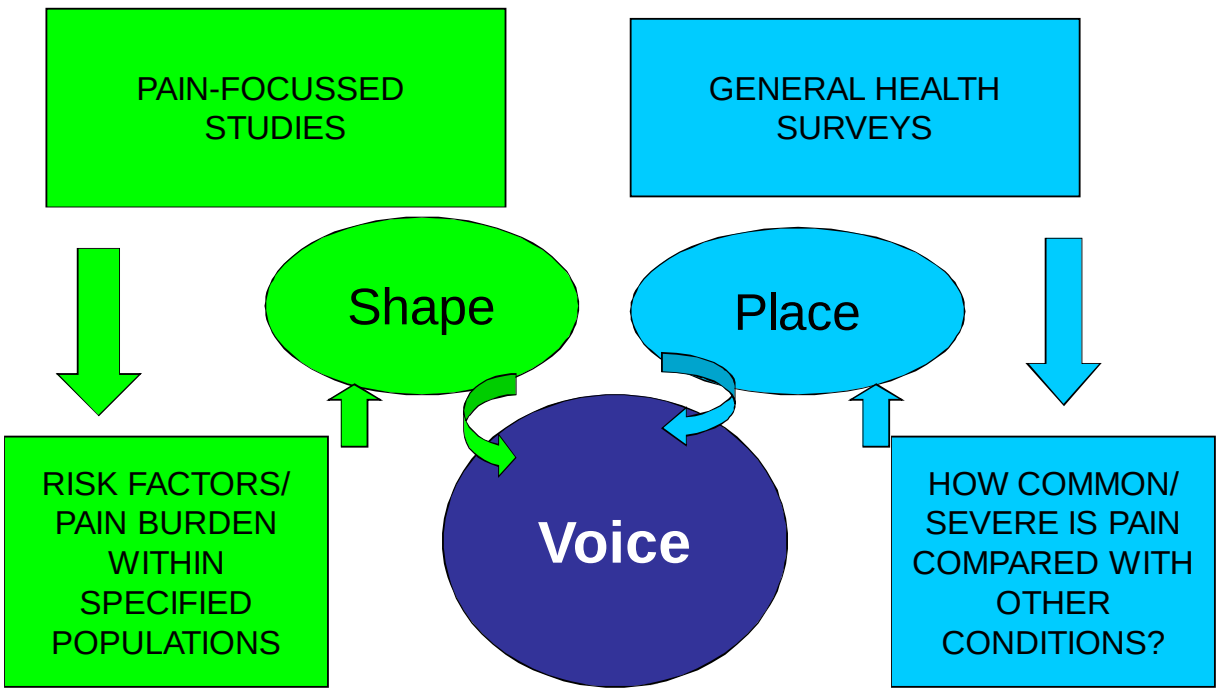
- Based on a range of reports using the same methods of costing, chronic pain had the **third highest** level of health expenditure ($34 billion per year)
- Chronic pain outranked cancer, depression, stroke, diabetes and asthma in costs

Without this information

- Pain has little or no visibility as a health care problem
- It is very difficult for chronic pain to compete with other more ‘established’ conditions for limited health resources
- Areas of unmet need go unnoticed

Giving pain a voice and a shape

Putting it together…



What is a public health problem?

- Lots of it
- Costly to individuals (health, quality of life)
- Expensive

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What is a public health problem?

- Lots of it
- Costly to individuals (health, quality of life)
- Expensive
- Population-level factors influence incidence and outcomes
- Strong 'social patterning'
- Acting at the level of individuals alone will NOT address the problem of population burden

We need a multi-pronged approach…

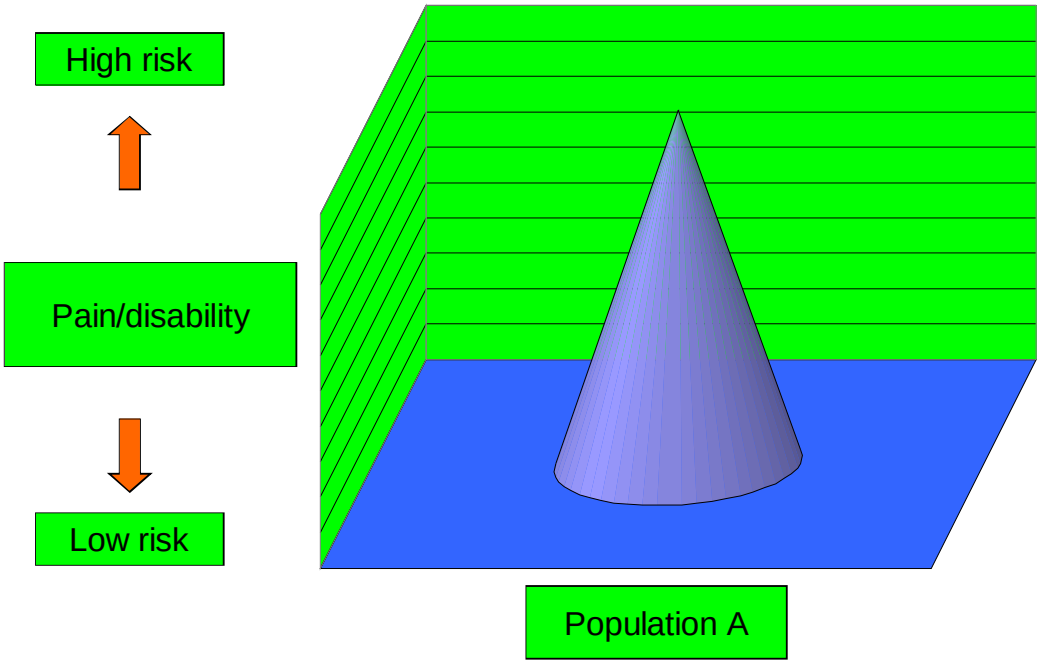
"…societal, lifestyle, and molecular explanations of disease are interconnected and mutually reinforcing, not stark alternatives locked in mortal combat" *Poole and Rothman J Epidemiol Community Health 1998*

In other words, the biopsychosocial model!

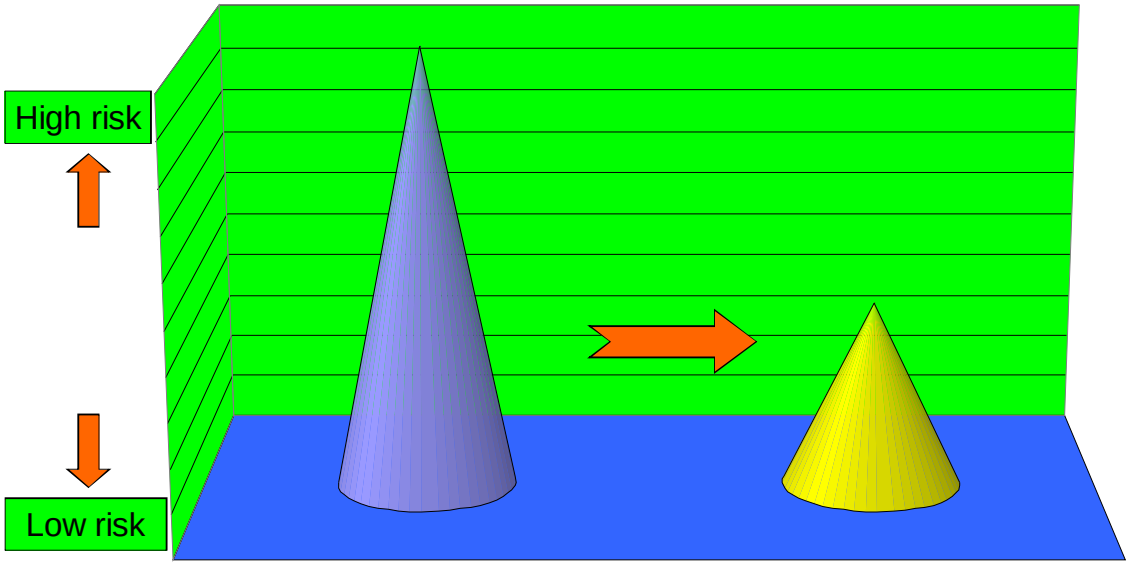
Why is the public health/population approach important?

- A high-risk individual approach to chronic pain will NOT succeed in reducing the problem at population level
- Important intervention targets will be overlooked if uniquely population-level risk factors are not identified
- We are not optimising our intervention strategies

The high risk approach



The population approach



Population A
More pain/disability

Population B
Less pain/disability

Thinking about risk factors

Unanswered questions about chronic pain

- Is there a threshold effect?
- What is the contribution of current vs. former pain?
- What is the contribution of childhood vs. adult-onset pain?
- What is the contribution of maximum pain versus duration of pain?
- At what level of pain does increased susceptibility to chronic pain begin?

- These questions are not new...

- There are other examples of recently-emerging public health problems, for example overweight/obesity…

These questions were being asked about overweight/obesity in 1989 *Barrett-Connor et al, 1989*

- Is there a threshold effect?
- What is the contribution of current vs. former obesity?
- What is the contribution of childhood vs. adult-onset weight?
- What is the contribution of maximum overweight versus duration of overweight?
- At what level of overweight does increased susceptibility to diabetes begin?

Pain is dynamic…

- Longitudinal studies show that chronic pain is dynamic over time
- Risk factors for *getting* chronic pain are not necessarily also risk factors for *staying* in chronic pain
- Risk exposures and pain experience are dynamic across the lifespan

Early life exposures also track for musculoskeletal functioning in adulthood

Rheumatology 2009;48:1181–1182
Advance Access publication 20 July 2009

doi:10.1093/rheumatology/kep213

Editorial

Musculoskeletal health—how early does it start?

Fiona M. Blyth, Gareth T. Jones, and Gary J. Macfarlane
Musculoskeletal health—how early does it start?
Rheumatology Advance Access published on July 20, 2009
Rheumatology 2009 48: 1181-1182; doi:10.1093/rheumatology/kep213

I Still Got It

Overview of talk

› recent evidence that helps define chronic pain as both a condition in its own right, and as a significant public health problem

› a population-focussed approach to managing the burden of chronic pain

› barriers to progress

Problems of competition:

- My disease is bigger than yours
- My disease is better-funded than yours

What we are up against

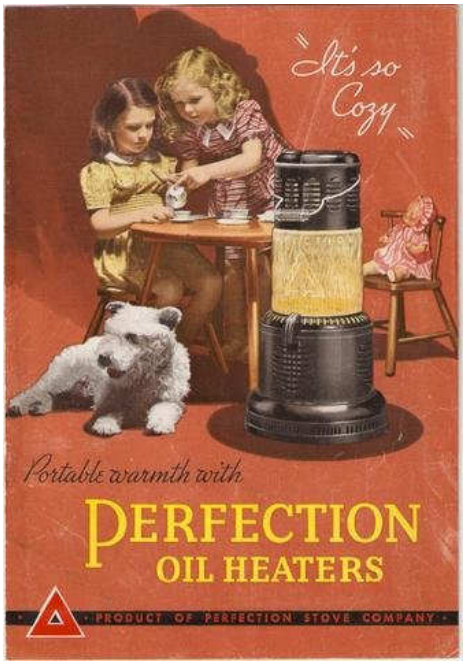
Problems of recognition:

- How do we give pain a ‘shape’ like cancer?
- Symptom vs. condition debate
- Case definitions
- Unambiguous coding within the health system (e.g. ICD codes)
- Disease registries

How does pain relate to other health priority areas?

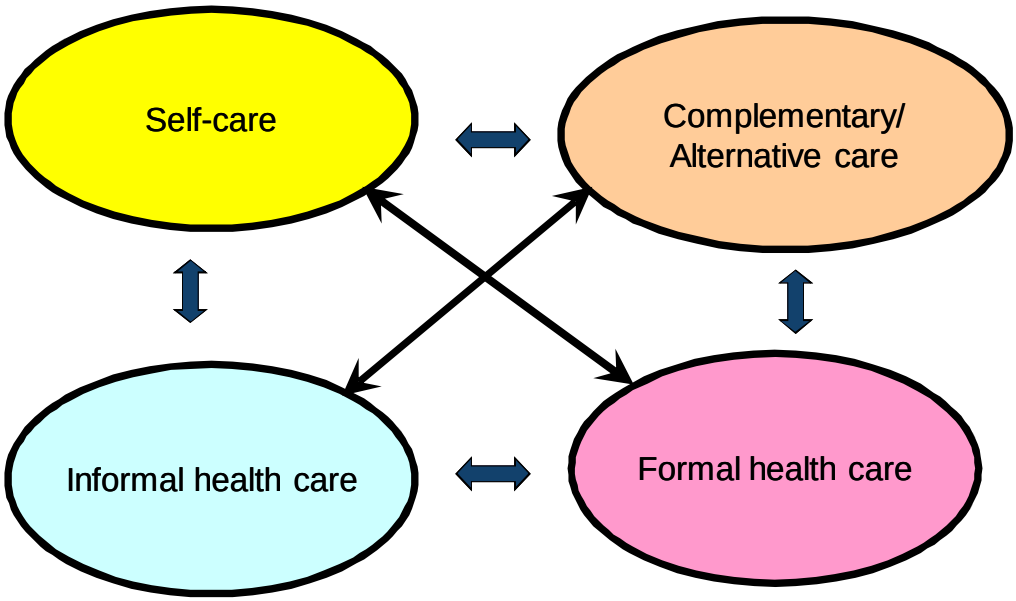
- Injury, musculoskeletal conditions, cancer, healthy ageing
- Pain as a long-term outcome of injury is rarely recorded

Models of care – the ideal world



- Abundantly well-funded
- Targeted at well-defined groups with clear potential to benefit from interventions
- Have a 'whole of population focus'
- Underpinned by effective, evidence-based interventions

Types of care used in the community



wwwpainsummit.org.au

Why was it the right time in Australia?

- Disease burden now known: 1 in 5 people
- Associated disability known
- Financial costs of $34 bn per year
- Chronic Pain increasingly seen as a disease entity
- BUT pain NOT on national radar
- Major changes to national health care system on the way

NATIONAL PAIN SUMMIT – AUSTRALIA who was involved

- Led by ANZCA / AFPM, APS and Consumer groups (Chronic Pain Australia & Consumer Health Forum)
- Inaugural supporters: PMRI and MBFF
- Grants from pharmaceutical, biotechnology and insurance companies
- More than 130 health & Consumer organisations
- Over 200 stakeholder participants
- Multidisciplinary input AND interdisciplinary input

NATIONAL PAIN SUMMIT – AUSTRALIA processes

- Steering Committee Meetings: Nov 08,Feb, Apr, June, Oct 09
- Working Groups: Models of Care, Primary Care, Evidence
- Leaders Meeting: ANZCA Sept 09
- Draft National Pain Management Strategy: launched Oct 09
- Summit: 11 March 2010

NATIONAL PAIN SUMMIT – AUSTRALIA activities

- Reference Groups – Acute, Cancer, Paediatrics, Geriatrics
- Consultation – Industry
- Visits – Canada, USA, UK – Oct – Nov 09
- Political advocacy – Oct 09 – March 10 & beyond
- Media program – Oct 2009 – March 10
- Pain Summit March, 2010 – Parliament House
- Next steps underway
- Montreal

DRAFT NATIONAL PAIN MANAGEMENT STRATEGY GOALS

- People in pain as a National Health Priority
- Knowledgeable, empowered and supported consumers
- Access to skilled professionals and evidence-based care
- Access to interdisciplinary care at all levels
- Quality improvement and evaluation
- Research agenda, adequate resources & translation to care

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THANK YOU FOR THE INVITATION TO SPEAK

- “If the world should blow itself up, the last audible voice would be that of an expert saying it can't be done”

Peter Ustinov