



## **APMA Submission**

**to the**

**Senate Standing Committee on Community Affairs  
Legislation Committee**

**inquiry into**

**the Social Security and Other Legislation Amendment  
Bill 2011 Schedule 3 (Disability Support Pension  
Impairment Tables)**

**August 2011**

## Who we are

The Australian Pain Management Association Inc. (APMA) is a 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 persistent (aka chronic) pain and supports individuals with persistent pain, and their families across Australia. The organization is head-quartered in Brisbane, and was established in 2009 in response to the need for evidence-based information and services for people living with persistent pain, and to provide a voice and community support for them, their carers and families.

APMA provides a number of services including:

- a website containing persistent pain information, management options and reliable and accessible information for people living with pain ([www.painmanagement.org.au/](http://www.painmanagement.org.au/));
- **Pain link**, a national telephone helpline service **1300 340 357**;
- community education and outreach;
- a network of pain support groups;
- lobbying for improved hospital, medical and health services.

As a result of its membership base, services and outreach, APMA deals on a daily basis with the impact of persistent pain, chronic disease and ill-health.

## Persistent pain in Australia

The management of pain in Australia remains shockingly inadequate, despite the efforts of health practitioners, consumer organizations and, belatedly, 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. The projected increase in total numbers is expected to be from around 3.2 million to 5 million people by 2015<sup>1</sup>. We are unaware of the number of people currently in receipt of Disability Support Pension (DSP) as a consequence of persistent pain, but in June 2007 the figure was reported to be 7400<sup>2</sup>. 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<sup>3</sup>.

## Introduction

APMA was invited to participate in the review of the Impairment Tables in August 2010, but funding and resource constraints prevented active involvement with the Advisory Committee during its deliberations. APMA has also been provided with advice of the outcome of the Advisory Committee's deliberations, and has carefully considered the report, the proposed new Tables and

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<sup>1</sup> Access Economics Pty Ltd *The High Price of Pain: The economic impact of persistent pain in Australia* MBF Foundation November 2007 p. iii

<sup>2</sup> Ibid p. 41

<sup>3</sup> National Health Priority Action Council *National Chronic Disease Strategy* Australian Government Department of Health and Ageing, Canberra 2006

associated documentation. APMA appreciates the opportunity to provide feedback and input for this Senate process and for consideration by those responsible for drafting the new legislative instrument and developing policies and programs to support the reform process and its objectives.

We have also provided feedback in similar terms to this submission to the Review Secretariat within the Department of Families, Housing, Community Services and Indigenous Affairs.

## **Our overview**

APMA welcomes the recent focus on assisting people to move from the Disability Support Pension (DSP) to participation in the paid workforce where that is possible. Many of our members, and other people living with pain, would greatly appreciate the opportunity to remain in, or return to, the paid workplace. We agree with the Advisory Committee's observations of the health and social benefits of work. These include not only the financial benefits, but also that working is generally good for health and well-being, and is important for identity, self-worth and social participation. Whilst some people with persistent pain are profoundly disabled and must be able to access the safety net which the DSP provides, those who have some capacity to work should receive encouragement and support to do so.

We support the change whereby work-related impairment is based on functional impairment, rather than a medical diagnosis, body-system based approach. We also support the removal of the tables from the Act, and their determination by means of a Legislative Instrument, enabling more regular review and updating. The major change to the previous practice of using a 'miscellaneous' table to assess pain, and assessing the functional impairment arising from the pain condition (or symptom where the pain results from another condition) should, we believe, be a positive change. The effect – if accompanied by an insistence on comprehensive investigation and reporting by medical practitioners - should help to address the current inadequate treatment of people living with pain whose condition(s) are not properly investigated, diagnosed or treated. Such individuals are currently just left to languish on a disability pension without access to effective rehabilitation or employment assistance.

The new impairment tables make it clear that a shallow medical report of 'pain' is unacceptable. "Pain is a symptom and not a diagnosis. It is important that the cause of pain is properly diagnosed and treated. There are a range of treatment options for the management of pain. Significant, ongoing pain that is not substantiated by the diagnosis of an underlying condition and a report from a medical specialist and/or pain management clinic requires consideration of whether the person's condition has been fully diagnosed, treated and stabilised." We agree that pain is not a diagnosis, but assume that the Advisory Committee, the HPAU and assessors will be aware of and accept pain medicine specialist diagnoses of 'persistent (or chronic) pain and a range of other pain conditions which are now recognised as disease states in their own right – and are, at times, of unknown aetiology or origin. In this regard we would strongly encourage liaison and consultation with the Faculty of Pain Medicine, consistent with recommendations 2 and 9 of the Advisory Committee's report, to ensure that the tables are consistent with recent developments in pain medicine.

## Aspects of the revised Tables requiring minor amendment

We believe that the wording of paragraph 35, which sets out how to assess the functional impact of pain should have the word 'or' substituted for 'and' so that it reads as follows:

“Pain is a symptom and not a diagnosis. It is important that the cause of pain is properly diagnosed and treated. There are a range of treatment options for the management of pain. Significant, ongoing pain that is not substantiated by the diagnosis of an underlying condition **or** a report from a medical specialist and/or pain management clinic requires consideration of whether the person’s condition has been fully diagnosed, treated and stabilised.”

This change would remove the possible confusion between pain (symptom) and pain (condition), often resulting from inadequate investigation, diagnosis and management experienced by people with persistent pain.

We also believe that the full extent of loss of function which can be associated with persistent pain may not be properly identified and assessed by the tables as they presently stand, which should be addressed via detailed consultation with the Faculty of Pain Medicine. Specifically, effects such as loss of concentration and memory arising from severe long-term pain, inability to sleep and/or medication side-effects; the restrictions arising from severe allodynia which may restrict the ability to wear the footwear or clothing required in many occupations; and the crippling restrictions which can arise with some cases of chronic pelvic pain such as endometriosis which do not appear to be clearly identified as being assessable under the revised Table 10.

## Further support required

APMA believes that additional actions will be required from the Government to ensure that the objectives of the Building Australia’s Future Workforce reforms are achieved. We note that the Advisory Committee, in Appendix G of its report identified a number of important issues beyond its terms of references. Included in these issues was a shortage of specialists and specialist services in some fields and locations. Pain medicine specialists and pain management services clearly fall within this category, and it is imperative that the Commonwealth Government ensure people with persistent pain can access appropriate diagnosis, assessment and treatment for their condition in a timely manner. All of the evidence shows that delays in assessment and treatment increase the severity and chronicity of the condition. A recent study prepared for the 2010 National Pain Summit identified that even where people were referred by their GP for investigation or specialist treatment, the 26 publicly funded pain facilities had a mean wait time of more than 180 days, ranging up to 575 days<sup>4</sup>. Any serious attempt to reduce the incidence, and work-related impairment, of people with disabling persistent pain will require a significant increase in the resourcing and availability of pain management services and facilities.

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<sup>4</sup> Hogg, M. et al *Waiting in Pain: a systematic investigation into the provision of persistent pain services in Australia*, Australian Pain Society 2010 p. 5

Persistent pain is not regarded as a chronic condition and addressed as part of the *National Chronic Disease Strategy*, or the various State policies which complement the national strategy. This is a deficiency which contributes to the inadequate diagnosis, treatment and management of persistent pain at the primary health care level. It also results in limited resources or focus on prevention, health promotion or self-management education except where the pain is associated with one of the identified conditions such as arthritis. This omission, and its consequences, seriously detracts from and undermines the achievement of the aim of the reforms which include the revised Impairment Tables.

Encouraging and requiring more flexibility and accommodations in Australian workplaces from employers (including access to assistive technologies) are also of critical importance.

### **Application of revised Tables to new applicants only**

The final, but perhaps most important, issue APMA wishes to raise is how the undertaking by the Minister that people currently in receipt of DSP will not be affected by the new Impairment Tables will be guaranteed. In an ABC interview on 30 July, Minister for Families, Housing, Community Services and Indigenous Affairs Jenny Macklin MP said “This will start on the 1st of January for people who are eligible from the 1st of January. So not people who are currently on the Disability Support Pension, that’s a very important point to make....” The only means by which this assurance can be given effect is to ‘grandfather’ the entitlement of current recipients to either be assessed against the current Tables and tests, or alternately retain eligibility even if found to be ineligible against the new Tables. We would expect the drafting of the new Instrument to reflect this undertaking.

This is a critical issue for APMA – many people with persistent pain and other medical conditions where pain is a seriously disabling element who are currently receiving DSP will be reviewed at some stage over the coming years. The possibility that the new assessment standards might be applied to them – with the associated requirement to attempt to return to work, or as is likely accept the lower payment of an unemployment benefit - will cause significant anxiety for many until and unless a clear commitment that current recipients are exempted from review under the new Tables is provided.

### **Conclusion**

It is important that these revised Tables are implemented prospectively, sensitively and with the maximum positive support and assistance to those seeking to ‘work through’ – literally and figuratively - their persistent pain. APMA does not want these changes to fail, because the result could involve merely moving people from a disability support pension onto the lower payment level and insecurity of an unemployment benefit.

APMA would welcome the opportunity to provide further information and advice in relation to any of the above issues.