Article

WORKERS COMPENSATION & SELF INSURANCE

The Opioid Crisis in Australia

By John Walsh

In my article published in November 2019 in relation to the American experience of the opioid crisis and what it meant for Australia, I outlined the development of the crisis in America which in October 2019 was described by President Trump as "*the biggest health emergency facing the nation*".

I refer to the Australian Bureau of Statistics report in September 2019 which, amongst other things, noted that "*Pharmaceutical opioids are present in over 70% of opioid-induced deaths… (and that)…the rate of opioidinduced deaths with synthetic opioids present has increased significantly over the last decade*".

I argue that Return to Work SA, as the statutory authority charged with the responsibility of administering the workers compensation scheme, has both a moral and a financial incentive to address the crisis. I also recognise the significant role that self-insurers play in the scheme. Self-insurers should also, as part of good claims management, recognise when opioids are used as a treatment of choice for pain-related complaints. The potential is now well-recognised for such treatment to turn into longer term treatment with increasing likelihood of addiction, harmful side effects and in the worse case scenario – death due to accidental overdose or suicide.

I acknowledge that Return to Work SA has combined with the Australian and New Zealand College of Anaesthetists and the AMA (SA) in a community campaign to combat the growing impact of opioid misuse and overuse. The centre point of the campaign is education and based upon a database accessed through "Reach For The Facts.com.au".

The database enables people to check whether the medication which has been prescribed for them is an opioid and it is also an educational resource base for health professionals.

While this initiative is very valuable and welcome, in my earlier article I argued that education alone will not stem this epidemic. **More needs to be done!**

In recent times the State Government has indicated an intention to initiate a real time notification system for doctors and pharmacists to minimise the risk of doctor shopping and the misuse of opioid medication. This is another welcome and important initiative.

Tasmania was the first Australian jurisdiction to implement a real time prescription monitoring ("RTPM") website.

Tasmania's per capita death rate from prescription opioids was approximately 30% above the national average between 2002 and 2006. Tasmania was Australia's poorest State and had the nation's highest rate of opioid packs sold per person, much like the American "rust belt states". Indeed one region in Tasmania still has the unenviable record of having the highest number of Government-subsidised opioid prescriptions in Australia – more than 110,000 for every 100,000 people.

Although RTPM is not mandatory in Tasmania, the Tasmanian experience shows that such programs are effective to a degree in improving clinical decision making, reducing doctor shopping and diversion of opioid medication.

Victoria followed Tasmania, but unfortunately, despite the fact that the Federal Government committed $16 million to creating a national system in 2017 with the aim of rolling it out by the end of 2018, it is yet to arrive.

It is important to point out that participation in the RTPM program is not mandatory in Tasmania or currently in Victoria and there is a natural limitation in its effectiveness because of that fact. I understand, however, that from April 2020 the Victorian RTPM model will be mandatory for all doctors and pharmacists.

If RTPM is to be introduced into South Australia, the Government must make participation mandatory to minimise the potential for doctor shopping. Even

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then it will not prevent border hopping unless a nationwide mandatory RTPM program is put in place by the Federal Government with cooperation from the States.

Big Pharma

The challenge is huge and not least because Big Pharma continues to contribute to the crisis, and in some cases does so by actively misleading general practitioners. MundiPharma was recently fined $302,400.00 by the Therapeutic Goods Administration ("TGA") for materials distributed to doctors and other health professionals in relation to its oxycodonebased drug, Targin. The TGA found that the company had misrepresented the position of two major doctors groups on how to prescribe medicines to those with chronic pain in order to promote the drugs. The TGA described the company's marketing to GPs as "*misleading, imbalanced and otherwise inaccurate*".

MundiPharma is the Australian arm of Purdue Pharma, the United States company behind OxyContin which, as I pointed out in my earlier article, is facing multi-million dollar legal challenges because of allegedly deceptive marketing practices amongst other things.

The amount of the fine is small change compared to the massive profits MundiPharma is making by promoting the use of opioids in the treatment of chronic noncancer, post surgery or acute pain.

Overworked GPs have been shown to be susceptible to the pharmaceutical companies aggressive and effective marketing through sponsoring conferences, training seminars, research papers and the like to push the use of opioids as the treatment of choice for pain.

GPs write the majority of opioid prescriptions and treat most cases of chronic pain and in many cases are ill-equipped to do so. Clinical experience in multiple studies have found that the patient's descriptor of the level of pain is not necessarily accurate. Individual pain ratings are well known to be influenced by multiple psychological and contextual factors. Patients with mental health and substance abuse problems are more likely to score their pain higher on a pain scale. Similarly, those who have suffered work injuries may consciously or unconsciously exaggerate their pain experience. Doctors feel an obligation to treat the reported pain and that obligation, coupled with inadequate medical training regarding pain management, leads many to take the path of least resistance to patients seeking pain relief and to prescribe opioids.

The Age, in an article on the subject dated 6 February 2020, quoted Dr Nick Carr, a GP at the St Kilda Medical Group who has run workshops for 20 years teaching GPs how to deal with doctor shoppers. Nick is reported as saying that, "*Doctors are not very good at saying no…They worry about things like: 'Oh my God, what if the pain is genuine?'*"

The use of opioids for acute pain, post-operative pain and cancer pain is accepted where symptom relief, rather than functional outcome, is the goal. The use of opioids for chronic pain is, however, generally inappropriate.

There are ample studies to illustrate that opioids for chronic pain should not be prescribed unless there has been a failure of pain management alternatives and the prescribing doctor, in an ideal situation, should carry out a full physical and psychological assessment and consider known risk factors before prescribing opioids as a treatment of last resort.

Rarely would an already overworked general practitioner have the time or the resources to conduct such an assessment or the follow up assessments required to demonstrate improvement in pain and function to justify continued opioid use.

It is well-recognised that the problems are magnified in rural and remote areas because people living in rural and remote areas generally have lower incomes and a corresponding lesser capacity to access appropriate health services.

It is less well-known that the problem is magnified in the workers compensation setting.

The link with workers compensation

In my November article I made reference to the opioid crisis commencing in the rural and regional areas of America, the so-called "rust belt" counties inhabited by working class families. Over time studies have shown that there is a greater prevalence of payments for opioids in workers compensation claims. Oxycodone in America and, in more recent times, Fentanyl became the go to medications for managing both short and long term pain resulting from injuries sustained as part of a workplace accident. In Australia in the workers compensation space, like so many others, we follow the American pattern.

In America, statistics compiled by the National Institute of Occupational Health & Safety, the National Safety Council and the Centres for Disease Control Prevention revealed a strong link between workers compensation and opioid addiction:

- In 2016, 44% of all workers compensation claims involving prescription medication exhibit at least one prescription for opioids.
- As of 2016, 15% of workers compensation claimants with at least one prescription for opioids have a date of injury going back six or more years.
- Data reveals that receipt of more than one week's supply of opioids – or two or more prescriptions – soon after an injury doubles a worker's risk of disability one year after the injury.
- Data for low back injuries that kept workers out of work for more than 7 days, revealed longer term workers compensation durations for those

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prescribed opioid medication compared with those claims that did not involve opioid prescriptions.

A 2008 study conducted by the California Workers Compensation Institute revealed that injured workers receiving high doses of opioid painkillers stayed off work three times longer than those with similar injuries taking lower doses. Moreover, the study found that workers who take opioids for more than three months usually do not return to work at all because of dependence issues or other side effects.

It is, therefore, hardly surprising that there exists a wealth of evidence from studies showing that claims costs for injured workers using prescription opioids are significantly higher, on average, than the claims costs of similar injuries sustained by workers who are not taking these painkillers.

I recognise that education of general practitioners and indeed patients is an essential element in the campaign to end, or at least curb, the scourge of opioid addiction, but I remain of the view that compensating authorities are in a unique position to influence behaviours.

Early intervention to put in place an interdisciplinary pain program when a prescription of opioid medication is being considered, or to support efforts to decrease or ideally cease opioid use should be a pre-requisite for pain management.

The development of guidelines/protocols to reinforce early intervention and put in place an interdisciplinary pain program when a prescription of opioid medication is being considered is essential. Such guidelines and protocols to support efforts to decrease or ideally cease opioid use should be a pre-requisite.

I understand that over 10 years ago WorkCover SA, through its medical and allied health team, attempted to address the opioid issue. Numerous multidisciplinary training sessions for practitioners were conducted and the team wanted to develop guidelines and protocols, however, at the time this did not come to fruition. It is not too late! Guidelines and protocols can and should be developed with a focus on five key elements:

1. early identification of risk factors to enable recognition of those who are at a greater risk of addiction;
2. continuous monitoring of the injured worker throughout the claim, with communication between the compensating authority's claims departments and the injured worker's treating practitioners;
3. collaboration between claims manager, treating physician, injured worker and specialist pain physician;
4. treatment guidelines to manage prescribing practices; and
5. education.

There are many alternatives to opioid treatment ranging from acupuncture and cognitive behavioural therapy to physical therapy and yoga. Indeed recent studies have shown that opioids are only slightly more effective than placebos at treating pain, other than acute pain, post-surgery and cancer pain.

For many years now it has been recognised that patients generally want a quick fix to end their pain and painkillers represent the solution. Overworked GPs have been shown to be susceptible to pharmaceutical companies aggressive and effective marketing. Government-subsidised opioids at about $6.00 a pack are a cheap and easy alternative to less harmful conservative treatments.

Compensating authorities can and should develop protocols which prioritise conservative care such as physical therapy, pain neuroscience education and multidisciplinary pain rehabilitation programs. This sort of approach may require an intensive and more costly period of treatment, but over the longer term would likely be shown to be cost-effective and do no harm to the patients who are being treated.

I strongly believe that compensating authorities are in a unique position to emphasise the alternatives to opioid treatment and influence behaviours which lead to safe alternatives to opioid treatment and help break the dangerous cycle of overprescribing, misuse and addiction of opioid medication. **All it takes is the will to do so!**

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