



FPM

Faculty of Pain Medicine
ANZCA

Parliament of Australia Select Committee on Women's Health Submission

*Faculty of Pain Medicine of the
Australian and New Zealand College
of Anaesthetists response*

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About the Faculty of Pain Medicine

FPM is the peak body for the training, continuing education and maintenance of standards for specialist pain medicine physicians across Australia and New Zealand. Fellows of FPM are super-specialists who already hold qualifications across a range of medical disciplines prior to their commencement of training with FPM.

This submission has been authored by a group of pain medicine physicians with a wealth of experience across many decades and with a large representation from specialist pain medicine physicians who also hold fellowship of Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

Summary

Pain is a common and disabling condition across the lifespan in the general population. However, women and girls are disproportionately affected by disabling chronic pain conditions at all ages when compared with their male counterparts. These disproportionate effects mean that the generally poor funding for pain management services disproportionately affects women and girls.

Whilst many pain conditions affecting women are related to painful disorders specifically related to female reproductive anatomy, it is also the case that many painful and disabling conditions are strongly over-represented in women. For many of these conditions, interventional procedures such as surgery or targeted pain interventions are neither appropriate nor safe.

Even in those conditions where surgical intervention might be justified, repeated surgical intervention can cause significant harm. Alternative, non-invasive treatment pathways are available and have been studied for decades. However, current funding structures frequently undermine attempts to provide effective, non-invasive care with deleterious population-based outcomes over the long term.

FPM makes the following specific recommendations:

- 1) Establish properly funded multidisciplinary pain management pathways for women and girls with persistent pain.**
- 2) Introduce routine identification and follow-up of significant pain during pregnancy and after childbirth.**
- 3) Reform Medicare and other funding arrangements to support complex, non-procedural pain care. This should include implementation of the Medicare Benefits Schedule Review Taskforce Report on the Review of Pain Management MBS Items (2020)**
- 4) Strengthen pain education across primary care, maternity care and relevant specialist disciplines.**
- 5) Ensure that cancer survivorship programs routinely identify and manage persistent treatment-related pain.**
- 6) Specifically identify and fund research priorities addressing outcomes that are important to patients.**

Background to the FPM submission

Noting the specific Terms of Reference (ToR) of the committee, FPM offers the following insights, where relevant:

ToR (a) and (b)

- a) *Best practice approaches to postpartum healthcare, including the delivery of physical and mental health support and services for mothers and their partners including those who have experienced infant loss;***
- b) *Women's experiences in the postpartum period, including the physical, psychological, emotional and economic impacts of birth;***

There are no formal publicly funded pain management programs for women in the post-partum period unless they have experienced significant obstetric trauma and complication. All women that have been pregnant, including those suffering early miscarriage, experience significant mechanical and physiological challenges of pregnancy. This increases their risk of developing pain through pregnancy and into the postpartum period.

This remains the case regardless of the mode of delivery. For example, a 2025 meta-analysis examining the incidence of chronic post-surgical pain after caesarean section found around one in 12 women experiencing persisting pain lasting more than 12 months after caesarean section in developed countries. Whilst, obviously, this represents a minority of women undergoing caesarean section, the well-documented increase in caesarean delivery through many nations, including Australia, highlights that this will become an increasing problem.

Additionally, peripartum injuries to the pelvis, pelvic nerves, birth canal, and perineum can all give rise to conditions associated with long-term pain. Despite this, available treatments and specialist access are mainly limited to services that provide physical or surgical remediation of secondary physiological dysfunction such as urinary incontinence. Specialist pain services providing assessment and multidisciplinary care for such conditions are sparse, concentrated in the private sector, and rarely available outside large metropolitan settings.

Inadequate treatment of continuing pain in this setting risks compromising physical function and mental health at a crucial time for mothers and newborn children. Inadequate identification and early management of painful obstetric injuries adds further risk of leading to chronic pelvic pain with major consequences on physical, psychological and sexual functioning.

FPM recommends that pain and associated disability should be assessed during pregnancy and, particularly, at the routine postnatal review. In situations where identifiable persistent pain conditions occur, specific pathways for reassessment and onward referral for specialist care, where appropriate, should be developed. During the antenatal period, pain should not be dismissed as a generic burden of pregnancy and onward referral to appropriate multidisciplinary teams should be a care standard. Where pain and associated functional impairment persists in the postpartum phase, an appropriate handover to specialist services for review should again be a standard of care.

ToR (c)**c) *Best practice pregnancy and postpartum care models to support long-term maternal physical and mental health.***

Pain is a common problem through all trimesters of pregnancy, but can be especially problematic in the final trimester due to a combination of increased skeletal loading and ligament laxity associated with gestational hormone effects. Separately, many women with chronic pain associated with chronic medical illness become pregnant whilst using medication to manage pain and maintain function.

Current antenatal care focuses on immediate harm prevention, addressing complications of pregnancy and the postpartum period with a potential loss of holistic approach to maternal physical and mental health outcomes. In pain management, this includes frequent advice to stop all medications related to treatment of pain and mental health conditions with little consideration of suffering this may cause to the mother, nor the adverse effects that untreated illness may have on the developing fetus.

FPM's recommendation for routine assessment of pain and disability (see above), with access to specialist assessment and multidisciplinary care where indicated, is appropriate to this area.

ToR (d)**d) *The cost and accessibility of postpartum healthcare, including:***

- 1. *infant feeding supports,***
- 2. *mental health supports and services,***
- 3. *physiotherapy services, including pelvic health services, and***
- 4. *related allied health services;***

Access to appropriate multidisciplinary pain management for women experiencing significant pain related to pregnancy, confinement or the postpartum period is very limited. In particular, understanding of the roles of both multidisciplinary intervention and medication management is minimal.

Access is particularly difficult outside metropolitan areas. Both medical and allied health provision relevant to multidisciplinary pain management are not integrated with maternity and postnatal care. This may leave women suffering persistent pain reliant on fragmented service delivery after routine obstetric follow-up has ceased.

As noted above, identification of problematic pain through pregnancy and the postpartum period with appropriate onward referral should be recognised as a care standard. This should include clear pathways between maternity services, primary care and more specialised services where required.

Additionally, psychological input should be recognised as an established part of multidisciplinary pain management without the need for a specific peripartum mental health diagnosis for onwards referral.

ToR (e)

- e) Antenatal and postpartum reproductive health support and education, including contraceptive care;**

Comment on this ToR is outside FPM's specific area of expertise

ToR (f)

- f) Research, education and training on pregnancy and postpartum care for healthcare professionals working in maternal care;**

Noting earlier commentary in this submission, FPM considers that education and training in the recognition, assessment and management of persistent pain could provide important benefits to pregnancy and postpartum care. In particular, greater attention should be paid to identifying those women at risk of developing persistent pain following pregnancy and childbirth. This would extend to those women with pre-existing pain conditions whose symptoms may be exacerbated through this period.

Education should align with the National Standards for Health Practitioner Pain Management Education but should also extend to include an appropriate understanding of pain mechanisms, together with pain management strategies relevant to pregnancy and postpartum care. Care teams should be competent to recognise those circumstances where referral to multidisciplinary treatment teams or a specialist pain medicine physician would be of benefit. In keeping with recommendations made above, assessment of pain and its impact on physical function should be incorporated into routine postpartum care as a care standard.

Additional research is required into other factors associated with exacerbation of pre-existing pain conditions through pregnancy, as well as the influence of reproductive hormonal changes on pre-existing pain conditions. This would also include research into prevention of the transition from acute to persistent pain.

When considering the implementation of such measures, it is useful to learn from the experience in provision of analgesia for women during labour. This has advanced enormously over recent decades, reflecting successful collaboration between anaesthetists, midwives and obstetricians. FPM holds the view that a similar collaborative approach to the assessment and management of pain arising through pregnancy and persisting after childbirth would be received favourably in this area, noting the interdisciplinary goodwill that allowed the advancement of effective labour analgesia.

ToR (g)

- g) existing Commonwealth, state and territory government policies, programs and healthcare initiatives addressing postpartum care;**

FPM acknowledges existing Commonwealth, state and territory initiatives to improve maternity and postnatal care. The National Women's Health Strategy 2020-2030 and the Australian Postnatal Care Guidelines both provide an important foundation for improving women's health following childbirth, although in their current iterations, neither publication offers more than the most basic advice on pain management.

FPM views existing structures as representing an opportunity to strengthen the recognition and management of pain through pregnancy and childbirth. Updating relevant national publications to include contemporary standards for pain education and multidisciplinary care would be a useful advance.

As noted earlier, implementation of a care standard for pain management into existing maternity and primary care pathways could facilitate the appropriate identification of persistent or disabling pain, appropriate follow-up, and pathways to more specialised pain management as and when required.

ToR (h)

h) data collection, reporting and monitoring processes and allocation of research efforts relating to postpartum healthcare;

FPM considers that improved longitudinal data collection and research could improve the understanding of pain throughout pregnancy and into the postpartum period. Existing maternity data collection systems should be strengthened to include appropriate measures of pain severity, functional impairment and recovery, including the effects of treatment.

Research priorities should also explore the natural history of pre-existing pain conditions through pregnancy and the postpartum period. Unfortunately, this is an area that has seen little analysis in the past beyond, as noted above, broad recommendations to withdraw any form of analgesic medication during pregnancy and in the postpartum period, particularly in breastfeeding mothers. The effects on women of such recommendations are largely unknown, as are longer-term consequences.

In recent years there has been some recognition of the development of longer-term pain conditions associated with pregnancy and delivery but granular data in this area is lacking, as is an understanding of treatment outcomes.

ToR (i)

i) The ways in which women and girls experience recurrent, severe, or long-lasting pain conditions;

Persistent pain is a common problem in the general Australian population. However, persistent, disabling pain is more common in women and this is well demonstrated in the latest statistics from the Australian Institute of Health and Welfare. The AIHW data demonstrates that in individuals through prime working age, slightly more women than men present with a disability, but when specific causes of disability are identified, there is a relative excess of around 16% in disability due to pain in women. This gap increases to a 20% relative excess in women over the age of 65. These figures are consistent with international literature across multiple nations, which consistently demonstrates a greater prevalence of chronic pain conditions in women.

The sex discrepancy in pain experience has been highlighted recently in the largest study ever conducted into pain experience. This examined the prevalence of pain in all stages of life across 118 nations with an analysis of data from more than 6.1 million individuals. The higher prevalence of pain in women was well-demonstrated across multiple common conditions (Ref: Fillingim M et al. Global and Regional Reference Curves for Pain Across the Lifespan in 6.1 Million Individuals in 118 Countries. *Nature Medicine*. 2026 <https://doi.org/10.1038/s41591-026-04696-w>)

The higher prevalence of intractable pain conditions in women has attracted extensive research and fundamental mechanisms have been identified. These include the impact of sex hormones on the brain and pathways within the peripheral and central nervous system. There are also important differences in visceral anatomy and associated neurological pathways. The major factors in the disproportionate female burden of pain have been well summarised in a recent review article in the prestigious US journal *Science*. (Ref: Venkataraman, A *et al* Sex Specific Mechanisms of Chronic Pain. *Science*. 2026. <https://doi.org/10.1126/science.aeh4468>)

The prominent burden of pain falling on women and girls can be seen in children as they pass through puberty. Before puberty, pain conditions, which are well described in children, occur equally in boys and girls. However, sex differences in pain prevalence become prominent after puberty and extend throughout the female lifespan.

Large scale epidemiological surveys have demonstrated significant sex differences in the prevalence of many conditions causing disabling pain. For example, disabling migraine appears to be between 2 – 3 times more prevalent in women than in men. Irritable bowel syndrome is around four times as prevalent in women as in men. Degenerative musculoskeletal conditions resulting in pain are around 50% more common in women.

When one looks at autoimmune disease, a common cause of serious musculoskeletal, neuropathic and nociplastic pain, the differences become even more substantial. For example, rheumatoid arthritis is approximately 2.5 times as prevalent in women when compared with men. Mixed connective tissue disease is around 3 – 5 times as common in women than in men, and systemic lupus erythematosus has a female:male prevalence ratio of 9:1.

Severe and debilitating nociplastic pain conditions such as fibromyalgia and complex regional pain syndrome similarly have a heavily female dominated prevalence, with ratios of approximately 5:1 for fibromyalgia and 3:1 for CRPS.

All the conditions listed above are recognised to be problems burdening both men and women, but the extent to which the burden falls disproportionately on women is underappreciated.

Additionally, there are specific health conditions that affect only women, and of these, pain conditions associated with disorders of the female reproductive system have tended to attract the most attention. Female specific pain, including dysmenorrhea, pelvic pain, pelvic girdle pain and vulvodynia are highly prevalent and impacted by reproduction. These conditions frequently overlap and it is common to see multiple pain presentations in individuals.

Chronic pelvic pain is common in women. A common error in interpretation is the assumption that all such pain is associated with specifically identified pelvic pathology, particularly endometriosis. However, consistent evidence over many years has demonstrated only a limited association between endometriosis (particularly superficial endometriosis) and pain, with endometriosis being found at a high prevalence in women with no symptoms of pelvic pain and, conversely, no features of endometriosis often being identified in women who suffer significant and disabling pelvic pain.

Many pain conditions can occur simultaneously in women and in such circumstances, focusing on only one area of pain symptoms, a common scenario in many medical specialist disciplines, treating a single identified pathology where there are separate overlapping pain syndromes is unlikely to yield lasting benefit.

Recent advances in oncology have seen remarkable improvements in survival after treatment of many solid tumours. This is particularly the case in breast cancer and pelvic cancers. However, such survival often comes with a cost of significant and persistent pain associated with the effects of surgery, chemotherapy and radiotherapy. Currently, limited appreciation of the adverse effects on quality of life for cancer survivors leads to unnecessary limitation of access to appropriate multidisciplinary care that could improve the outlook for cancer survivors.

As an example of a common cancer diagnosis affecting women, a 2020 meta-analysis demonstrated that, after breast cancer surgery alone, around half of all women undergoing such surgery reported persistent pain at the surgical site, and furthermore, 27% reported moderate to severe pain persisting over many years. Chemotherapy treatment for breast cancer has also greatly improved survival in recent years but again, at the cost of secondary problems with long-term pain.

For example, taxanes can be effective agents in breast cancer treatment but are associated with a high prevalence of chemotherapy-induced peripheral neuropathy, with around half of all women undergoing such treatment reporting chronic moderate to severe pain and with the majority of women reporting pain lasting over many years. Pain arising in such circumstances can certainly be treated. However, many women in such situations are either not offered treatment or are told to accept the fact that ongoing pain is simply the price of survival.

The fundamental differences in pain experience between men and women are primarily physiological, not simply pathological. Nevertheless, this fundamental difference in causality remains misunderstood and, in many situations, unaccepted. As a consequence, treatment directed towards symptom relief continues to see an emphasis on remediation of anatomical pathology and anomalies, often through surgery, even in settings where there is good evidence that such patterns of intervention can cause harm and are generally not associated with reliable improvement.

In parallel, multidisciplinary approaches to pain management remain chronically underfunded, despite a better evidence base for efficacy and much lower risk of harm. This misallocation of resources will always have a disproportionately negative effect on women, due to the higher burden of pain they suffer throughout the lifespan.

ToR (j)

j) *women's experience in seeking appropriate healthcare responses to pain, including experiences of medical misogyny;*

FPM recognises that patients with persistent pain often report negative experiences in their interactions with healthcare professionals. Frequently, such experiences involve feelings of rejection, symptom dismissal and even suspicion. Such experiences are not confined to women, although population surveys indicate that women report negative experiences of this type much more frequently than men.

The fact that such issues occur may imply negative attitudes towards female patients by health providers. However, it may also reflect the difficulty many health providers report in dealing with circumstances where patients suffering chronic pain present with complicating psychological and social factors. Many clinicians have difficulty in accepting reports of severe pain and functional impairment when there is poor correlation with investigation results. Unfortunately, this very limited understanding of complex chronic pain is exactly the outcome that could be predicted where health provider training has emphasised the primacy of detecting and treating visible

pathology rather than developing a deeper understanding of the complex neurophysiology and psychology underpinning chronic pain presentations. This is a direct consequence of inadequate education in pain management that is seen through all levels of the healthcare system, from undergraduate training through to postgraduate specialist qualifications.

Poor understanding of pain all too easily leads to dismissal of findings and again, the fact that pain is much more common in women will result in a disproportionate burden of negative healthcare experience falling upon women and girls. While gender bias can contribute to the dismissal and undertreatment of women's pain, inadequate education in pain management is also a significant factor. Addressing both issues is essential to improving women's experiences of healthcare.

FPM considers that improvements in health practitioner pain management education should be prioritised across all levels of health provider education and should be a core part of continuing professional development requirements.

ToR (k)

k) *Barriers to effective pain management, including the range and affordability of available treatments;*

As has been detailed above, persistent pain is a complex condition requiring an integrated approach to assessment and management. Healthcare services, in contrast, are often organised around specific clinical "silos" with a particular focus on specialist management of groups of disease states. Such approaches are inconsistent with best practice in pain medicine which emphasises multidisciplinary assessment and management, including detailed clinical assessment, physical rehabilitation, psychological support, health education and self-management. Such approaches strive to improve pain, functional status and social participation whilst minimising the iatrogenic harm that can arise due to excessive reliance on either medication or interventional treatments.

Poor funding for multidisciplinary pain management will, for the reasons highlighted above, always result in compromised care for women and girls who suffer a disproportionate burden of complex, chronic pain conditions.

Funding of pain services in the secondary and tertiary care sector serves a vital purpose in managing complex pain presentations, primarily in public hospitals. However, services are severely stretched, typically with very long waiting lists for cases that are deemed to be non-urgent, which typically represents the majority of referrals. Additionally, these services are highly concentrated in major urban centres. Provision of care in regional and rural regions is sparse.

A significant barrier in current funding systems is the major disparity between funding for procedural interventions and funding for complex, non-procedural pain management. The discrepancies are substantial and it is easily demonstrable that funding is much greater for the remuneration of technical skills when compared with remuneration for equally important clinical skills. This can act as a perverse incentive which moves funding towards low value care, involving repeated interventions that are not accompanied by definable improvement.

Previous recommendations for Medicare reform

Reform of funding systems, particularly Medicare, was recognised in the National Strategic Action Plan for Pain Management (2019) developed by the consumer organisation, Pain

Australia, with specific funding from the Australian federal Department of Health. The plan identified timely access to multidisciplinary pain management, supported by appropriate primary care funding models, as a national priority. It specifically called for pain to be recognised as a complex condition in its own right for the purposes of MBS rebates. The National Strategic Action Plan was formally endorsed by the federal government together with many other peak health provider and consumer bodies.

In 2020, a review into pain management items in the Medicare Benefits Schedule was published with its independent recommendations being directly forwarded to government (Ref: [Medicare Benefits Schedule Review Taskforce: Final Report on the Review of Pain Management MBS Items](#)).

This review recommended substantial reforms to improve access to evidence-based multidisciplinary pain care. The recommendations included specific addition of funding structures that could support community-based multidisciplinary pain management programs and improved referral pathways from specialist pain medicine physicians to Medicare funded allied health services.

The review also recognised the complexity of clinical presentations within the complex, chronic pain environment and specifically recommended that specialist pain medicine physicians be granted access to the complex care item numbers 132 and 133 or, in the alternative, to define separate pathways to recognise the clinical commitment required to provide such care. In the six years since the publication of the review, none of these recommendations have been implemented. FPM has made repeated representations to federal governments and Medicare in this respect and no progress has been made. Inevitably, poor funding support will translate into reduced service provision and again, the effects of this will fall disproportionately on women and girls.

In parallel, it should be noted that during 2025, the Medicare Benefits Schedule was expanded to grant access to complex care item numbers 132 and 133 to Australian sports physicians. This decision raises legitimate questions about policy priorities, given that enhanced funding was directed towards sports medicine while women and girls with disability continue to experience significant unmet healthcare needs and remain poorly served by the health system

ToR (l)

l) Best practice approaches to assisted reproduction treatments;

Comment on this issue is outside FPM's area of expertise

ToR (m)

m) Access and affordability issues relating to fertility and assisted reproduction treatments;

Comment on this issue is outside FPM's area of expertise.

ToR (n)

n) The regulation of medical devices used in women's healthcare treatments, including risk assessments, monitoring and reporting;

AND**ToR (o)**

- o) The role of relevant regulators and other agencies in responding to complaints regarding medical devices;***

FPM maintains a close working relationship with the TGA, providing specialist advice on the safety and effectiveness of medical devices employed in pain management. FPM considers that the current national framework provides a solid foundation for patient safety. FPM supports the TGA's continuing efforts to strengthen ongoing, postmarket surveillance of medical devices.

ToR (p)**Any related matters**

Pain research is badly underfunded and often overlooked by major funding bodies. The reasons for this are manifold, but a recurring problem is that too often, pain is simply seen as a symptom consequent upon disease activity. An implication is drawn that targeting the disease will result in a reduction in pain.

There are multiple clinical situations where this is not the case, but perhaps one of the best examples is that of chronic pain in cancer survivors, as noted above. In this situation, important research identified effective means of improving survival in a situation that, in previous years, might have been associated with a poor prognosis. However, the consequence of treatment is survival from cancer with a lower quality of life than would be desired and little, if any, ongoing research into remediating the latter.

A welcome development in research funding ethics in recent years has been the collaboration between researchers and patients to develop research priorities that address outcomes that are important to patients. For women with chronic pain conditions, reduction of their symptom burden and improvement of function are the most important priorities and, as such, a better focus on pain research through major research funding organisations would address this very important issue.



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