Submission

Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26

Independent Health and Aged Care Pricing Authority

Via email to submissions.ihacpa@ihacpa.gov.au

Submission by the **Australian Physiotherapy Association**

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Acknowledgement of Traditional Owners

The APA acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, sea and community. We pay our respect to their Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander Peoples today.

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

About the Australian Physiotherapy Association

The Australian Physiotherapy Association's (APA) vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing, and that the community recognises the benefit of choosing physiotherapy. The APA is the peak body representing the interests of Australian physiotherapists and their patients. It is a national organisation with state and territory branches and specialty subgroups.

The APA represents more than 32,000 members. The APA corporate structure is one of a company limited by guarantee. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

We are committed to professional excellence and career success for our members, which translates into better patient outcomes and improved health conditions for all Australians. Through our National Groups we offer advanced training and collegial support from physiotherapists working in similar areas.

Table of Contents

1. Executive Summary

Introduction

The Australian Physiotherapy Association (APA) is pleased to provide feedback to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26 (Pricing Framework). The APA supports the work of the Independent Health and Aged Care Pricing Authority (IHACPA) and their essential role in ensuring transparent and fair pricing structures for hospital and aged care services.

Physiotherapists play a vital role in Australia's hospital system by assessing and treating a diverse range of patients and conditions. They work across multiple areas and collaborate closely with interdisciplinary healthcare teams to provide comprehensive care. Their contributions are essential for optimising patient outcomes and facilitating safe and timely discharge from hospital.

The APA isn't in a position to provide feedback on all consultation questions. However, there are components of the Pricing Framework that we believe need to be amended to align with contemporary service delivery to accurately record services provided by physiotherapists in our public hospital system.

APA position

Tier 2 Non-Admitted Service Classification

The Tier 2 Non-Admitted Service Classification (Tier 2) definition manual in Australia requires updates to better align with contemporary models of care, particularly concerning advanced practice (AP) physiotherapy. Advanced practice physiotherapy has become integral to the healthcare landscape, with highly experienced clinicians providing specialised non-admitted services to patients referred to medical consultants. These physiotherapists operate autonomously, utilising advanced skills in assessment, diagnosis, and management planning for complex conditions. However, the current classification system fails to distinguish the unique role and responsibilities of AP physiotherapists, hindering appropriate recognition and funding allocation.

Unlike nurse practitioners, who are included in the classification codes with Medical practitioners reflecting their advanced clinical roles, AP physiotherapists lack suitable codes within the Tier 2 structure. The existing codes do not account for the extended appointment times and increased complexities inherent in AP physiotherapy services. This discrepancy not only undermines the value of AP physiotherapy but also limits the incentive for hospitals to implement innovative and efficient service models, despite evidence showing their efficacy and cost-effectiveness in alleviating pressures on the healthcare system.

To ensure the sustainability and growth of AP physiotherapy services, there is a need for a distinct classification within the Tier 2 structure. This classification should accurately reflect the higher costs and specialised nature of AP physiotherapy, enabling hospitals to allocate appropriate resources and incentivising the adoption of best practices. By recognising the vital role of AP physiotherapists and providing adequate funding mechanisms, healthcare organisations can optimise patient care delivery and promote the continued advancement of physiotherapy services within the hospital setting.

Conclusion

The APA thanks the IHACPA for the opportunity to provide feedback into this submission. We would welcome the opportunity to work with the IHACPA to support accurate recording of physiotherapy services, including in AP physiotherapy clinics, in our public hospitals.

2. APA's response to the consultation questions

3.1 Classifications used to describe and price public hospital services

Q1. What, if any, barriers are there to pricing emergency department services using the Australian Emergency Care Classification Version 1.1 without a shadow pricing period for NEP25?

APA response:

The APA has no feedback on this question.

Q2. Are there any other proposed refinement areas to be considered in the development of an updated version of the Australian Emergency Care Classification?

APA response:

Our members report patient presentations to the emergency department (ED) are becoming increasingly complex with needs that may not require medical intervention, rather assessment of function and psychosocial issues that require the skills of a multidisciplinary team. For example, when a patient presents to ED who is no longer independently managing at home.

The current list of ICD-10-AM Principal Diagnoses Short List is focused on medical conditions rather than impairments and psychosocial complexities, with the principal diagnoses not always matching the type of presentation being managed.

It is therefore unclear how the Australian Emergency Care Classification (AECC) is capturing the increasing complexity of ED presentations and if the pricing framework is reflective of the resourcing required to support a multidisciplinary care approach in the ED to prevent admission.

Data collected to inform pricing of the AECC could, in future, incorporate the number of different professional groups engaged to provide care. The APA would also recommend the consideration being given to the resource implications required by those presenting with complex social and medical care needs.

Q3. Are there any barriers or known issues associated with reporting patient level data, specifically in relation to reporting principal diagnosis and patient's age in emergency services?

APA response:

There is a need for standardised training and education for staff responsible for the input of patient data to ensure consistent and accurate entry.

In many emergency departments (ED) there are a variety of health care professionals who are responsible for the input of patient data, this includes physiotherapists, nurse practitioners, rotating medical interns, residents and senior doctors. This creates the potential for a lack of consistency, particularly with the input of principal diagnosis, where there are different options that could be attributed to the same presentation but attract different funding.

Q4. Are there any other proposed refinement areas to be considered for the Tier 2 Non-Admitted Services Classification for NEP25?

APA response:

The APA recommends that the Tier 2 Non-Admitted Service Classification definition manual is amended to include specific codes for advanced practice physiotherapy services that is weighted to reflect the higher level of autonomy and professional responsibility of these roles.

The Tier 2 Non-Admitted Service Classification (Tier 2) definition manual requires refinements to reflect contemporary models of care in Australia's public hospital system. This is specifically in relation to advanced practice (AP) physiotherapy where a new funding tier is needed for AP physiotherapy clinics.

Advanced practice physiotherapy is an established part of the Australian healthcare landscape. Physiotherapists working in these clinics are highly experienced clinicians who have undertaken additional qualifications, through postgraduate master's level award or equivalent, and credentialing. They operate with a high degree of autonomy and professional responsibility, providing non-admitted services for patients referred to, and who would otherwise be seen by, a medical consultant.

Together with advanced communication, collaboration, advocacy, professional leadership and scholarship characteristics, they work with a scope of practice that may fall within or outside the traditionally accepted scope of physiotherapy practice. As such, physiotherapists who work in AP clinics have a different role to what is expected of a typical outpatient physiotherapy service. They are accountable for assessment, diagnosis and management planning for patients presenting with complex, undifferentiated or undiagnosed conditions. Appendix 1 provides further information regarding AP physiotherapy in Australia.

Like nurse practitioners, physiotherapists in these roles are authorised to function autonomously in an advanced clinical role, however unlike nurse practitioners physiotherapists cannot be classified in the relevant class within the medical consultation services (20 series). For example, for AP physiotherapists working in Orthopaedic/Musculoskeletal Physiotherapy Screening Clinics, the only Tier 2 codes that are available are:

- Physiotherapy 40.09 PW = 0.31 $200
- Orthopaedics 40.44 PW = 0.0309 $200

These codes aren't fit for purpose as they don't acknowledge the difference in service between an AP physiotherapist delivering diagnostic and management pathway planning consultations in lieu of a medical practitioner and a physiotherapist in a general physiotherapy outpatient clinic delivering physiotherapy assessment and treatment services. Due to the complexity of the role and patient cohort and increased responsibilities of AP physiotherapists, appointment times in AP clinics are longer than in typical outpatient services. For example in Queensland, musculoskeletal physiotherapy screening clinic new appointments in Orthopaedics (40.44) are typically 60 minutes in length and undertaken by AP physiotherapists. Whereas general physiotherapy outpatient services (40.09) are typically only 30 minutes and conducted by base grade staff.

As Tier 2 definitions don't reflect the higher costs of AP physiotherapy services, there is no incentive to implement effective and innovative service models. There are a number of efficient models of care that position physiotherapists as the gatekeepers of hospital based care. These models have shown that AP physiotherapists provide safe, effective and highly cost-effective patient care alleviating pressures on our hospital systems.

In order to ensure the sustainability of these services, there is a need for distinct AP physiotherapy classification. Hospitals implementing best practice, using evaluated and cost efficient models, such as AP physiotherapy services, should be recognised with being able to allocated Tier 2 codes that are weighted accordingly, such as is the case with nurse practitioners.

Q5. What, if any, barriers are there to pricing admitted and community mental health care services using the Australian Mental Health Care Classification Version 1.1 for NEP25?

APA response:

The APA has no feedback on this question.

Q6. Are there any persisting barriers to collecting activity data following the COVID-19 pandemic response? If so, what potential strategies could IHACPA use to support states and territories overcoming these barriers?

APA response:

The APA has no feedback on this question.

Q7. What data-driven processes can be used to determine the efficient cost of teaching and training services to improve the transparency of block-funded amounts provided for these services, ahead of a potential longer-term transition to ABF?

APA response:

Physiotherapy activity data is collected manually creating an administrative burden for physiotherapists. Due to the time and resources required for data collection, there are health services that have ceased capturing data specific to teaching and training of physiotherapy and allied health more broadly.

To ensure accurate collection of physiotherapy teaching and training data, processes need to be automated to decrease the administrative burden placed on clinicians. This includes having systems integrated with existing workflows and electronic medical records.

Where data is being collected, there isn't the opportunity to record the increased resourcing required in delivering patient care. In physiotherapy, students who undertake clinical care are supervised by registered clinicians. In these situations it takes longer for the student to provide a service event and usually involves additional time of the supervisor.

To accurately determine the cost of teaching and training services, measures need to include the additional time taken by students to deliver patient care when compared with a qualified clinician and also the supervisory time required. A potential solution could be the development of a metric for care provided by physiotherapy students.

There is also variation in business rules relating to data collection and the way activity data is manually collected across allied health professions and services. This questions the integrity of the data collected.

3.2 Setting the national efficient price

Q8. What evidence can stakeholders provide that demonstrates the costs and changes to models of care associated with the COVID-19 pandemic response have persisted into 2022–23, or changed over time?

APA response:

The APA has no feedback on this question.

Q9. What principles and processes could guide an appropriate pricing response to significant disruptions to the health system, including natural disasters and epidemics?

APA response:

The APA has no feedback on this question.

Q10. Should the ICU adjustment be restricted to a list of eligible hospitals? If so, what factors should be considered in determining the level of ICU complexity, required to be eligible to receive the ICU adjustment, noting that individual units cannot be identified in the current national data collections?

APA response:

The APA has no feedback on this question.

Q11. Are there any barriers to a tiered adjustment that would allow for different ICU adjustment prices to apply, based on the characteristics of eligible hospitals or episodes of care within those hospitals?

APA response:

The APA has no feedback on this question.

Q12. Are there any barriers to including a fixed national weighted activity unit adjustment for eligible hospitals, regardless of activity levels?

APA response:

The APA has no feedback on this question.

Q13. To support IHACPA's investigation, what factors may help explain the reduction in the Indigenous adjustment, observed in recent years? Additionally, what factors should be considered in refining the calculation and application of the Indigenous adjustment, so that it reflects the costs of public hospital services for Aboriginal and Torres Strait Islander peoples across Australia?

APA response:

The APA has no feedback on this question.

3.3 Data collection

Q14. How should IHACPA account for the changes in data reporting when developing a costed dataset?

APA response:

The APA has no feedback on this question.

Q15. How can IHACPA ensure that the data collected is an appropriate, representative sample and that data collection methods account for changes to health system reporting capacity?

APA response:

There is variation in how data is currently collected which has resulted in inconsistencies between health services and professionals. This could be improved with standardised education and training in addition to regular monitoring and auditing.

Q16. What quality assurance approaches are being implemented at the hospital or state and territory level that should be considered by IHACPA to apply to national data collections?

APA response:

The APA has no feedback on this question.

Q17. What changes would enhance the user experience and functionality of the National Benchmarking Portal to inform improvements in public hospitals, and policy making?

APA response:

The APA has no feedback on this question.

3.4 Pricing and funding for safety and quality

Q18. What impact has the introduction of the pricing approaches for sentinel events, hospital acquired complications and avoidable hospital readmissions had on public hospital service delivery?

APA response:

The APA has no feedback on this question.

Q19. To inform the further development of safety and quality measures, are there other pricing related approaches that could be used to reward high quality care? How can IHACPA identify such care in national data collections?

APA response:

As stated in our response to question four, there is a need to acknowledge the advanced level of care provided by AP physiotherapists within the Tier 2 Non-Admitted Services Classification.

For admitted care, the current DRG (Diagnosis-Related Group) funding model poses challenges for allied health professionals, such as physiotherapists, in delivering high-quality care. Due to time constraints, allied health practitioners often find it difficult to provide comprehensive services. Unfortunately, when services face difficulties, the allocation for allied health resources tends to decrease. This not only leads to discharge delays but also restricts the valuable input that allied health can offer in patient care. To address this issue, incorporating specific components related to each allied health profession within the DRG framework is crucial. By doing so, we can collect data that highlights the resourcing needs necessary to support optimal patient care and enhance overall quality.

Further, the collection of activity data is significantly influenced by the demands placed on allied health professionals who support individuals eligible for or enrolled in the National Disability Insurance Scheme (NDIS). These professionals allocate substantial time to conducting NDIS assessments and preparing related reports. However, it appears that the existing pricing frameworks do not adequately account for these specific requirements. As a result, the true resource investment in NDIS-related services remains unacknowledged within the current pricing structures.

Our members have observed a notable shift toward inpatient care being administered through home programs. While this transition offers convenience, it has implications for activity data. Home models that replace traditional admitted care directly impact the data collected. Specifically, physiotherapy services delivered in a home model tend to be significantly fewer compared to inpatient care. Additionally, the costs associated with travel are compounded by the increased expenses related to supervision and mentoring for care provided within home models.

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3. Appendix 1

Physiotherapy range of clinical practice position paper