Feedback from Directors of Physiotherapy Services Queensland Health (DOPSQ) & Queensland Musculoskeletal Physiotherapy Screening Clinic and Multi-disciplinary Service Network (QMPSC & MDSN) re IHACPA Pricing Framework for Australian Public Hospital Services 2025-26 Consultation May 2024

The Directors of Physiotherapy Services Queensland Health (DOPSQ) is a group comprised of Directors of Physiotherapy Services in Queensland public sector health services. It functions to collaborate on workforce and professional issues impacting the delivery of physiotherapy services across the state and provide advice to relevant stakeholders.

The QMPSC & MDS Network is a collaborative of senior clinicians working in advanced physiotherapist led services, providing an alternate model of care for the management of patients referred to Specialist Outpatient (Non-Admitted) Services across 18 Queensland Health facilities and Mater Hospital Brisbane.

We appreciate the opportunity to provide feedback on the Pricing Framework for Australian Public Hospital Services 2025-26. Below is feedback on selected consultation questions relevant to the delivery of physiotherapy services in Queensland public hospitals.

Consultation Question 4: Are there any other proposed refinement areas to be considered for the Tier 2 Non-Admitted Services Classification for NEP25?

Response: Yes, revision of the Tier 2 Non-Admitted Services Classification is recommended to better reflect contemporary models of providing Non admitted services, which includes recognition of the nature and costs of alternate models of care.

Background

1. **Advanced Physiotherapist led models of care have been widely implemented in Queensland Health Non admitted services.**
   For example, the Musculoskeletal Physiotherapy Screening Clinic (MPSC) has been in operation for almost 20 years, manages a large volume of referrals in Non-Admitted/ Specialist Outpatient Services (approx. 17 000 annually) and has been demonstrated to be a safe, clinically effective and highly cost effective alternate model of care for patients with musculoskeletal conditions referred to many Specialist Services including Orthopaedics, Neurosurgery, Maxillo-facial, Rheumatology and Neurology[1] .

2. **Advanced Practice Physiotherapists are expert clinicians who are accountable for assessment, diagnosis and management planning for patients presenting with complex, undifferentiated, or undiagnosed conditions**. They operate with a high degree of autonomy

and professional responsibility, providing Non-Admitted services for patients referred by General Practitioners to, and who would otherwise be seen by, a Medical Consultant (eg Orthopaedic or Neurosurgeon).

3. **The widespread implementation of Advanced Physiotherapist led models of care in Non admitted Specialist Outpatient services has NOT been appropriately recognised and accounted for in the Tier 2 Non-Admitted Services Classification definitions, weighted activity and pricing structures**, which do not reflect contemporary practice or the costs of delivery of these services.

Specific Issues to be Addressed in Refinement of Tier 2 Non-Admitted Services Classification

1. Nurse Practitioners are included with Medical Officers in '20 series' codes which are assigned higher WAU and funding; while Advanced Practice Physiotherapy service can only be allocated to '40 series' codes.
   However, like Nurse Practitioners, Advanced Physiotherapists are Senior clinicians making independent assessment (including investigation), diagnosis and management pathway decisions in circumstances where there is a high degree of complexity and uncertainty, which should be reflected in the Classification.

   For example, in MPSC, Advanced Physiotherapists are providing assessment, diagnosis and management pathway decisions for Non-Admitted patients referred for Specialist Medical consultation in many specialty areas (Orthopaedics, Neurosurgery, Rheumatology, Maxillo-Facial, Neurology), which is a completely different role to providing physiotherapy treatment services.

2. Although Advanced Physiotherapy clinics are currently classified in the 40 series, appropriate '40 series' Tier 2 Classification codes are not available in all Non Admitted specialty areas in which Advanced physiotherapy screening clinics operate.
   For example, there are no relevant codes in Neurosurgery or Maxillo- Facial specialties, in which advanced physiotherapy models of care occur.

3. '40 series' codes are only available in some of the single specialty areas in which advanced physiotherapy clinics operate and are not available for pathways that draw from multiple medical specialities.
   For example, contemporary health services for patients with musculoskeletal spinal pain may be combined in some health services into a single spinal pain pathway (e.g. combined Orthopaedic/Neurosurgery Spinal pathways), but no relevant Tier 2 code exists which mean services may default to using the general physiotherapy outpatient treatment code (40.09) which does not reflect the nature of the service, the level of expertise required and the additional costs.

4. The lack of difference in WAU and price weights for codes currently used for Advanced Physiotherapist led clinics (eg.40.44; 40.39) from general physiotherapy outpatient services (40.09) are not reflective of the difference in costs of delivery of Advanced practice clinics.

   Advanced practice clinics are conducted by senior clinical staff with higher level of expertise and post graduate (Masters level) qualifications, who perform a different role (assessment/ diagnosis/ care pathway planning for patients referred to specialist medical services). The appointment duration in these clinics is usually longer than typical outpatient Physiotherapy treatment services.

For example in Qld, MPSC 'new' appointments in Orthopaedics (commonly assigned to 40.44) are typically longer in duration and conducted by HP5 level staff; compared to general physiotherapy outpatient / non admitted treatment services (40.09) which are typically 30 min in duration and conducted by base grade (HP3/4) staff at lower wage rates (Wage rates – Health practitioners | Queensland Health . This means that the advanced practice physiotherapist consultation may cost at least double the cost of the general non admitted physiotherapy treatment physiotherapy service to deliver and yet in 2024/25 will attract the same revenue. Advanced practice physiotherapist led services have been compared with traditional non admitted care provided in Orthopaedics and found to be 1) highly cost effective[2] and 2) more cost effective than traditional orthopaedic service delivery[3] .
The Tier 2 pricing does not reflect the higher costs of Advanced practice services and provides a disincentive to implement effective and innovative service models.

5. There is also lack of clarity between our Hospital and Health Services on how Advanced Physiotherapist led clinics are coded, either under Physiotherapy 40.09 or under the related medical specialty clinic e.g., orthopaedics40.44. A suggested solution would be to have a specific code for Advanced Physiotherapist led clinics, preferably in the '20 series'. Alternately, if to remain within the 40 series, then revision is required to 1) reflect the range of specialty areas in which these services operate, 2) reflect the higher cost and value of these services; 3) account for pathways that combine referrals from multiple specialties; 4) future proof the classification for expansion into new specialty areas

References

1. Raymer, M., Swete Kelly, P., & O'Leary, S. (2024, 2024/04/01/). Developing and embedding an advanced practice musculoskeletal physiotherapy service in public specialist outpatient services in Queensland: A health service masterclass. Musculoskeletal Science and Practice, 70, 102917. https://doi.org/https://doi.org/10.1016/j.msksp.2024.102917
2. Comans, Raymer, O'Leary, Smith, Scuffham (2014) Cost effectiveness of a physiotherapist led service for orthopaedic outpatients, Journal of Health Services Research and Policy 19(4) 216-223. DOI: 10.1177/1355819614533675
3. Standfield, Comans, Raymer, O'Leary, Moretto, Scuffham (2016) The efficiency of increasing the capacity of Physiotherapy Screening Clinics or Traditional Medical Services to address unmet demand in Orthopaedic Outpatients: A Practical application of discrete event simulation with dynamic queueing, Applied Health Economics and Health Policy, DOI 10.1007/s40258-016-0246-1

Consultation Question 7: 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

Clinical Education of Physiotherapists does add a burden to the delivery of patient care. In physiotherapy, students are seeing patients are are supervised by clinicians. This means that it takes longer to for the student to provide a service event to the patient and usually it involves additional time of the educator.

Measures should include the additional time it takes the student to see the patients compared with a qualified clinician and also the supervisory time required by the qualified clinician to also deliver the care/service event to a particular patient.

Consultation Question 9: What principles and processes could guide an appropriate pricing response to significant disruptions to the health system, including natural disasters and epidemics?

Appropriate/equivalent funding of virtual models of care(not less funding) and other alternate models of care that needs to be stood up. This included multidisciplinary models.

Consultation Question 15: 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?

Using similar measures as the Health Round Table does in assessing the quality of the data provided.

Consultation Question 19: 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?

Tier 2 Non-admitted data: The costings developed seem to favour efficiency over quality. The more efficient you seem over time, the more the cost goes down. In physiotherapy there is only one cost price, and it doesn't consider the different services provided by physiotherapy nor the experience or post-graduate qualifications of the physiotherapist.
For example, a 30 minute consultation performed by a new graduate physiotherapist attracts the same price as a specialised physiotherapist working as a consultant, seeing a patient for 1 hour instead of the orthopaedic surgeon. There is no consideration of the role nor the time in seeing these patients.
There are different prices for Nurse Practitioners and medical consultants but not for advanced physiotherapy consultants.
It may take 30 minutes for a physiotherapist to see a common musculoskeletal issue but to see someone with a neurological condition can take an hour. There are codes for different areas of medicine, so why isn't there for physiotherapy and other allied health professions.

For admitted care, the wrapped up price for a DRG doesn't fully encompass the input of the physiotherapist or other allied health professionals which does add to the quality of patient care, even with complex presentations. When services have difficulty, the allied health service provision is decreased and many hospital allied health services are running on minimal resources and can't input fully into the patient's care and enable timely discharge of patients. Including a specified allied health component into DRGs would improve the quality of care given to these patients.