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Dear Dr Sherbon

**Teaching, training and research costing study – consultation paper**

Through its membership of the IHPA Teaching Training and Research Working Group (TTRWG), the AMA has taken a close interest and active involvement in the development of an activity based funding model for teaching, training and research (TTR). The AMA has appreciated this opportunity and acknowledges the significant body of work undertaken by IHPA to date.

The AMA considers this project to be particularly important in recognising and determining the most appropriate funding model for these activities which are critical to the ongoing operation of public hospitals. The costing study provides a significant opportunity to systematically explore the feasibility of applying activity based funding (ABF) methodology to TTR. We have provided some comments and suggestions below to assist with the costing study.

In general terms, it is critical that any costing and classification work does not contribute to locking in place inadequate funding for TTR activity for public hospitals, in perpetuity. The TTR costing study should not be used as part of an overall methodology that looks simplistically at multiple jurisdictions with an overriding emphasis on reducing cost/price and fails to consider quality/outcomes/assessment of performance as being as important as the unit price. Development of a costing and classification model for TTR should actively consider possible approaches to include quality.

The AMA recognises ABF is not a panacea for all funding problems facing public hospitals, but if implemented correctly ABF has potential advantages over approaches based on historic funding levels with inadequate indexation.

The AMA looks to ABF in general as a means of systematically identifying and classifying activities as a logical basis for determining the full funding required to deliver those activities. This in turn should ensure that public hospitals have the capacity to deliver

activities on an ongoing basis. ABF should also assist in comparing activities across and within hospitals and identifying unexplained and potentially unwarranted variations.

In relation to TTR, there is much work to be done before an informed decision can be made to apply ABF to TTR activity. The costing study is a critical component in this process. It is also critical as a means of ensuring that TTR activity is not lost or obscured in other hospital activities and gets due recognition in funding and performance processes. It is important that this work continues to its end point, irrespective of Federal Government policy, to inform the development of an ABF model for TTR classification.

In this regard, and in relation to ABF more generally, there is a need for this costing study and other IHPA consultation papers to set out more explicitly how the benefits of ABF will be retained for the community and other stakeholders in our public hospitals regardless of policy changes in particular jurisdictions, ie set out strategies to ‘future-proof’ the relevance and gains of ABF.

The AMA is comfortable with the methodology and approach applied to progressing this work to date, and the current *TTR Costing Study Public—Consultation Paper* (the Paper) appears well-thought-out and comprehensive. While the paper provides some context for this work, any public information on the project e.g. through the proposed website, could usefully include additional information about the previous work undertaken, and end points for this project. This would enhance understanding of the scope and intent of this project, and the TTR work overall.

Investment in TTR is critical to the future of the health system. The AMA has supported this work from the outset on the basis that an appropriate funding model for TTR should:

- support the maintenance of a highly qualified and well-trained medical workforce through the provision of clinical training and maintenance of research in public hospitals; and
- provide medical students and graduates with a quality clinical training experience from medical school through to the completion of vocational training.

The AMA led a group of medical stakeholders in October 2012 to develop a set of principles and objectives to underpin any future funding models for teaching and training. These remain relevant and the costing study team should actively refer to these principles and objectives as work progresses. The principles are attached to this submission.

Throughout the TTR project, the challenges associated with unbundling teaching and training (T&T) from clinical service delivery have been discussed at length. While acknowledging these challenges, we would encourage this project to capture this data to the maximum extent possible to inform this, and future, costing model/s.

The AMA urges early and ongoing stakeholder engagement with trainees and clinicians to ascertain the best approach to data collection for this project. It is not clear from the paper how this will be achieved and whether the requisite skill set has been/will be consulted in the development of the methodology. This will be particularly important in the development of data collection methodology for the embedded costs of TT.

The public consultation paper is also light on detail regarding the proposed data sources. The AMA notes that the data sources are critical to the creation of an accurate price. The costing study should be clear on the margin for error in the proposed model. Any final model which underestimates the true cost of delivering TTR will not be acceptable to the AMA.

The AMA's comments on the consultation questions posed in the Paper are attached.

If you have any questions, in the first instance please contact Ms Sally Cross on (02) 6270 5433 or [scross@ama.com.au](mailto:scross@ama.com.au).

The AMA welcomes further opportunity to comment on the work that the TTR Costing Study Technical Group (TTR CTSG) will undertake, and looks forward to participating in foreshadowed stakeholder consultation workshops to validate the outcomes from Stage 3 of the current process.

Yours sincerely

A handwritten signature in black ink, appearing to read 'B. Owler', written in a cursive style.

A/Prof Brian Owler  
President

28 January 2015

bo:sc:mm

## Consultation questions

### 1. Is it reasonable to use a 'mixed' costing approach, whereby:

- **direct and embedded T&T are costed using a bottom-up approach; and**
- **indirect T&T and overheads are costed using a top-down approach?**

Yes. The AMA believes this approach is both reasonable and practical.

### 2. Are there any specific T&T activities (refer to step 1 of the T&T costing methodology) that should be captured as part of the costing study?

It is essential that clinical supervision inputs, by both specialists and doctors in training are captured, as well as any other activity related to the oversight of T&T. This includes the time required to prepare for supervision and T&T.

The time given to specialists and doctors in training to focus on their learning as well as service provision should also be collected.

In this respect, we would like to see the following data items captured:

- Number of clinical supervisors (headcount and FTE)\*
- Number of clinical supervisor hours/days (face to face and administrative)\*
- Total number of hours of teaching and training time\*
- Number of teaching and training support staff
- Number of days attending accredited training courses\*
- Number of days covered to allow attendance at accredited training courses\*

\*Specialists and doctors in training.

The study should consider including TTR activity undertaken out of hours/in clinicians own time, such as clinical audits. Whether these activities are paid or unpaid, they contribute to TTR activity and represent a TTR related cost and benefit, whether funded or not.

### 3. How important will it be to capture embedded T&T that occurs in conjunction with patient care?

The AMA believes it is critical to capture embedded T&T due to the significant postgraduate 'on the job' training that occurs within medicine. Failure to capture embedded T&T would significantly limit the value of the costing study.

The complexity of medical supervision and training, and the positive and negative impacts of T&T on service delivery, have been discussed at length throughout this project. It is acknowledged that these impacts will vary at different points in training, and that it would be extremely worthwhile to attempt to account for the relationship between stage and complexity of training and service benefit. For example, vocational training is more complex but the cost of providing training can be offset by the contribution of the trainee to service delivery.

The task of unbundling clinical service delivery from T&T in medicine is clearly one of the most challenging aspects of this project. Clinicians are a primary source of information for this part of the project, and must be actively engaged at a participating site level from the outset. Data sources and samples must include hospitals of all sizes that undertake training.

**4. Do you think that embedded T&T can be aligned to the amount of other (direct and indirect) T&T taking place in hospitals?**

No. We do not see how this could be practically achieved or how it would add to the overall purpose of the project.

**5. Is it practical or feasible to capture embedded T&T?**

As indicated in Q3, capturing embedded T&T represents one of the most challenging and perhaps most interesting tasks associated with this project. Whether it is practical or feasible will be determined by this study. The methodology outlined in this paper to achieve this is supported and the importance of consulting with clinicians and trainees is again highlighted.

**6. If so, should the study aim to capture costs associated with**

- **trainees and trainers not actively participating in patient care;**
- **reduced productivity; and/or**
- **consumable use increase.**

Participants at the medical stakeholder meeting held in October 2013 to discuss the feasibility of introducing ABF for T&T agreed that the concept of net cost of T&T should be explored in conjunction with the concept of service benefit. As indicated in Q3, this will be different at different points in training, and will be influenced by prior experience, skill set, length and intensity of training and supervision requirements, and variations in training requirements.

Other factors influencing net cost include the extent to which the pro bono contribution of clinicians providing teaching and training is factored in, the costs of accrediting training positions, access to emerging teaching and training technologies such as simulation, and individual trainee contributions to training.

**7. How might embedded T&T be captured in a way that is robust, delineates T&T from patient care and also minimises impost on clinicians, trainees and health services?**

The approach to collecting embedded T&T data proposed in the paper appears to be a reasonable way forward. Other sources of primary information may also include operating lists, outpatient clinic lists, as well as any other clinician and trainee record inputs that may be able to add context and granularity to data e.g. trainee log books if accessible.

Other methods may include but are not limited to:

- measuring efficiency losses due to T&T occurring, particularly in defined clinical episodes of care such that occur in outpatient clinics and operating theatre lists;
- quantifying the proportion of episodes of care primarily managed by the trainee. Again, outpatient clinics and operating theatre lists are clearest situations that this can be calculated either by auditing operative records or billing details in clinics; and
- comparisons between major teaching hospitals and hospitals with no trainees. For example, a private hospital may do five major surgical cases in an afternoon while a public hospital with trainees may do three.

**8. Are there any other important considerations that should be taken into account when deciding whether embedded T&T should be in-scope for data collection?**

No. The paper already acknowledges the need to keep the time impost on individuals to a minimum. A range of methods for capturing embedded T&T have been discussed, and we have emphasised that these should be explored further with clinicians and trainees.

**9. Are there any specific research products (refer to step 1 of the research costing methodology) that should be captured as part of this costing study?**

None that we are aware of. The difficulties associated with capturing this information have already been acknowledged and this should be a best effort collection which can be further refined.

**10. Is there any data that should be collected, which does not appear in Appendix B?**

In addition to the data items outlined in Q2 in relation to supervision and attendance at accredited training courses, it is important that the costing methodology is clear about the approach it will take to account for PGY3+ doctors, some of whom will be in non-accredited/service positions.

**11. Are there any data items listed in Appendix B that you believe are unnecessary?**

We are not confident that the list incorporates a definitive or 'correct' approach to capturing embedded T&T. As discussed, often both clinical service delivery and TTR are delivered in the same instance at the same time. This aspect would benefit from further work, consultation with relevant experts, and advice from the TTR CSTG.

**12. What systems exist (for example, within health services, jurisdictional health departments or peak bodies) that can provide the data items in Appendix B?**

The approach to collecting this data as described in the paper appears reasonable. We welcome further advice as to how this approach will be applied in practice.

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## Funding models for medical teaching, training and research: Objectives and principles

2012

On Thursday 18 October 2012, a range of organisations involved in medical education and training met in Melbourne to discuss funding models for teaching, training and research (TTR). The following objectives and principles for a future funding model were agreed.

### Background

- Medical graduate numbers have grown rapidly since 2004 with nearly 4000 graduates expected by 2016.
- Adequate funding of teaching, training and research (TTR), and the measurement and maintenance of its quality, will be essential to ensure that Australia's health care remains at a high standard.
- A funding model is needed for TTR that provides every medical student and graduate with a quality clinical training experience from medical school through to the completion of vocational training. It should encourage innovation, support medical research and the translation of research into evidence based practice.
- Significant future deficits have been identified in other parts of the health workforce. It is essential that adequate funding is maintained for TTR for medical training.
- Sufficient numbers of high quality training places must be available for graduates throughout the medical training pipeline. These should align with health workforce planning and projections with information being updated and publicly reported on a regular basis.
- This will result in improved patient safety and quality of care, and better health outcomes.

### Broad objectives

An appropriate funding model for TTR should:

- support the maintenance of a highly qualified and well-trained medical workforce through the provision of clinical training and maintenance of research in public hospitals.
- provide medical students and graduates with a quality clinical training experience from medical school through to the completion of vocational training.
- maintain quality clinical supervision and assessment across the continuum of medical training.
- recognise the core research role of senior clinical teachers and fellows in hospitals and deliver a base level of funding upon which specific research grants can build. This would incentivise hospital administrators to value clinical research and the application of its findings.
- cover the reasonable expenses of providing effective, comprehensive, high quality health services including TTR, service development and quality improvement without imposing unnecessary red tape and layers of bureaucracy.
- take into account the full range of teaching and training activities in public hospitals to enhance patient care. The majority of clinical teaching and training in public hospitals is delivered in conjunction with patient care. Funding mechanisms must adequately

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recognise these 'integrated' activities and reflect the numbers of medical students and junior doctors coming through the system.

- reflect the breadth and complexity of work performed in a public hospitals and recognise the resource demands of TTR activities and slower patient throughput associated with teaching and training.
- funding models must be robust enough to accommodate changes in both cost and volume over time, and be responsive to feedback.
- be incentive neutral to provide for high quality teaching and training across all settings (for example private and expanded settings), and to accommodate the need for increased training expansion as required. It is essential that any funding model does not create disincentives to train in settings beyond public hospitals, and should not undermine other funding or training models.
- consult with the clinical TTR community to ensure the funding model reflects the true costs involved and does not create perverse incentives.

#### **Specific principles**

- TTR should be seen as core business for the health system.
- TTR should be seen as an investment for a sustainable quality health service.
- Funding models for teaching and training (TT) should be separate from research (R).
- The concept of net cost of TT should be explored in conjunction with the concept of service benefit.
- Classification and adjustment systems must acknowledge elements such as prior experience, skill set, length and intensity of training and supervision requirements across the continuum of medical education and training and across specialities.
- Whether funding should follow the trainee or be allocated to the health service provider on an annual basis should be investigated.
- Mechanisms to compensate for changes in cost and volume growth within TT and R must be identified.
- Funding for TT and R must align with a national workforce plan. Pricing and costing frameworks must be linked to a national workforce plan to ensure the equitable distribution of TT funds in line with workforce demand, requirements for training places, distribution and community need. It is integral that Independent Hospital Pricing Authority and Health Workforce Australia work together to achieve this objective.
- A robust data set on the cost and volume of teaching and training activities is fundamental to improving the reliability of any funding model for TTR.

#### **Accountability framework**

An appropriate funding model for TT and R should:

- be linked to a suite of publicly reported key performance indicators (KPIs) for TTR to enhance quality and accountability and mechanisms must be put in place to monitor the performance of the health system in relation to TT and R activities.
- not provide incentives for 'gaming' and inaccurate reporting of KPIs for TT and R.



- clearly articulate the relationship between higher education funding and funding for TT and R. This includes transparency around the distribution of funds for TT and R between the higher education and hospital interface.
- provide mechanisms for regular review of the effectiveness of the funding model for TT and R and further refinement as necessary.

### Actions

It is recommended that the IHPA:

1. establish a working group to provide advice on the preferred funding approach, time line, transition path and associated work program. Membership on this group should include but is not limited to:
  - AMA
  - AMACDT
  - MDANZ
  - AMSA
  - CPMEC
  - CPMC.

(It is noted that IHPA has committed to such a consultative and advisory process).

2. establish a baseline for how TT and R is currently funded to inform evaluation of the validity of future funding models;
3. conduct a thorough literature review on the international experience of funding models for TT and R, and for disaggregating and unbundling the costs of TT and R to inform the development of an ABF model;
4. develop a costing/funding model for TT and R with a suggested time line of 31 December 2013;
5. pilot and evaluate this model(s) in 2014 prior to any decision to implement it more broadly;
6. make a recommendation to the Minister on the preferred funding model(s) for TT and R if possible by 31 December 2015; and
7. where practicable, make a recommendation to the Minister on the preferred evaluation and reporting framework for TT and R to ensure transparency and accountability of the preferred funding model(s).

This document has been formally approved by the following organisations who attended the Securing funding for teaching, training and research meeting on 18 October 2012:

- Australian Medical Association (AMA)
- Australian Medical Students' Association (AMSA)
- Australian Salaried Medical Officers Federation (ASMOF)
- Medical Deans Australian & New Zealand (MDANZ)
- The Australasian College of Emergency Medicine (ACEM)



