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Dr Tony Sherbon
Chief Executive Officer
Independent Hospital Pricing Authority
Level 6
1 Oxford Street
SYDNEY NSW 2000

Cc: submissions@ihpa.gov.au
deanmckay@paxtonpartners.com.au

Dear Dr Sherbon

Teaching, Training and Research Costing Study – Public Consultation Paper – December 2014

Thank you for the opportunity to comment on IHPAs *Teaching, Training and Research Costing Study Public Consultation Paper*, released in December 2014.

As you know, Universities Australia (UA), through our Health Professions Education Standing Group (HPESG), has a keen interest in the work IHPA is undertaking, particularly the treatment of teaching, training and research for Activity Based Funding (ABF) purposes. We welcome the opportunity to contribute to the process, and appreciated having the opportunity to discuss the Consultation Paper with the project team from Paxton Partners in January.

It is important to understand our response to the Consultation Paper is framed by our fundamental view that teaching, training and research are core and critically important functions of Australia's public hospital systems. As UA has indicated in communication with IHPA previously, one of the key strengths of our health system has been the willingness of hospitals and universities to work closely in educating our highly skilled health workforce. Likewise cross-sector research collaboration is an inherent strength of both systems and delivers major benefits to both, and the community at large. Neither should be put at risk.

Universities Australia understands the primary purpose of the current exercise is to identify activities that are and should be conducted in public hospitals – including teaching, training and research - and to develop funding mechanisms that ensure resources are targeted to those activities. As such, we understand the IHPA process aims to ensure teaching, training and research (TTR) are supported effectively in future.

We commend IHPA for recognising the importance of TTR in Australia's public hospital system and for persevering despite the inherent complexity of the task. The approach described in the

One Geils Court
Deakin ACT 2600

GPO Box 1142
Canberra ACT
2601
saustralia.edu.au
AUSTRALIA

Ph: +61 (0)2 6285 8100
Fax: +61 (0)2 6285 8101

contact@universitie

www.universitiesaustralia.edu.au

Consultation Paper demonstrates a good appreciation of the complex issues involved. The iterative and trial-based approach should help in developing workable options for Ministers and policy makers to consider.

Similarly, other aspects of the approach – such as, identifying *direct, indirect* and *embedded* cost components; exploring both top-down and bottom-up costing methodologies in relation to specific activity areas; and explicitly recognising the overlap between TTR activities and patient care – show that the IHPA and Paxton Partners is a sensible progression of the previous work in this area, and reflects an informed view of the potential benefits and pitfalls of applying ABF to these inherently complex and embedded arrangements.

We also encourage IHPA and the project team to acknowledge the benefits that come 'into' the public hospital system from investment in TTR activities. For instance, as well as being facilitators of research, public health services are among the greatest beneficiaries of research – a point that has helped underpin collaboration over decades. It is important therefore to ensure funding arrangements encourage continuation of teaching, training and research in public hospitals.

While it may be difficult to identify all of the cost elements that contribute to TTR activity, it is perhaps more difficult to identify (in any quantifiable sense) the benefits or returns from investing in these activities – such as a more skilled workforce, staff attraction and retention, improved quality of care and/or efficient practice that flows from research. While timing lags and other factors make attribution and impact difficult to assess, they nonetheless need to acknowledged at least, or risk being lost.

Another complexity, reflecting the extent to which TTR activities have been shared over many decades, is the existence of major hospital infrastructure that has been provided through universities, and the considerable (often pro-bono) teaching and research flows to health services that may not be captured in a one-way ABF process. The project will need to take account of these 'legacy' arrangements, as well as variable practice in government funding, including instances where governments have provided universities with resources that have been passed on to hospitals, and vice versa.

Teaching and training

Public hospitals continue to provide a crucial and possibly disproportionate share of the clinical education undertaken by students studying for entry level practice to most health professions. While there are arguments that a greater portion of clinical education should be undertaken in other health settings, public hospitals will continue to be at the core of clinical education. Questions about overall system capacity and resourcing to deliver clinical education aside, the ABF process should equip state and territory health managers to target teaching and training resources to public hospital facilities where it is actually being delivered and to best effect.

The proposed approach of distinguishing the profession of the trainee and the stage of training (for teaching and training activities) is encouraged. This will be necessary to determine the relative costs and benefits associated with taking on students, many of whom make a positive service contribution especially as they progress through their course. The project team might also consider whether identifying location or site data alongside this information, in view of possible differences in support requirements and contribution, is warranted.

In section 2.4.2 (Table 2), the paper identifies functions undertaken by health service staff likely to contribute to TTR (e.g. clinical education, clinical administration, finance etc). It may be helpful, given varying practice across the system, to note that these functions may not all be undertaken in discrete or identifiable work units. Similarly, the extent to which such functions are undertaken within hospitals, by universities instead, or in conjunction with the health service, is likely to vary across pilot sites.

It is important to ensure the study is designed to capture these differences, and similarly to ensure any ABF models that come out of this work are able to be capture changes in practice (e.g. such as a university establishing and funding a coordination position within a hospital).

In rolling the project out, it would be helpful if the project team included examples of a broader range of health disciplines in explaining their approach.

Other issues that are important to consider as the project progresses include:

- Developing TTR arrangements in such a way as to ensure possible funding options don't distort decisions about how hospital and broader training systems work or act as a constraint on innovative practice. For instance, the arrangements should not lock TTR activities into a specific setting;
- Taking account of differences in curricula requirements (eg. for nurses and midwives), which variations may be allowed or encouraged, and if in some cases data (and the collection processes) may only be meaningful (and useful) at an aggregate level; and
- Recognise that TTR activities are not only complex and variable (depending on factors such as location, history staff profiles and their networks etc) but are also being undertaken in a dynamic policy and service environment. It is important to assume TTR arrangements and their funding mechanisms will be operating in fluid environments.

Another aspect of teaching and training that may need to be considered is the provision of support, such as accommodation, for activities undertaken in rural areas. This may be a cost, but potentially also a benefit to the health service.

Research

Many of the factors that contribute to research capacity in public hospitals are hidden or hard to determine, but are nonetheless real. As mentioned above, it is important that research continue to be undertaken in public hospitals. There are serious risks to the health system if this function of public hospitals is devalued. Research not only contributes to health system capacity and performance, but drives system efficiency and improved practice.

The embedded, decades-long involvement of public hospitals in research has helped develop and underpin quality practice across our health system and capability in our health professionals. The Consultation Paper attempts to address this concern to some extent, but acknowledges "it remains unclear whether the embedded component of T&T can be separately identified." (refer to page 8, with further discussion at Section 3.5).

As noted for Teaching and Training, the embedded nature of university infrastructure in public hospitals makes this complex but cannot be ignored. If the ABF process develops into an accounting exercise that seeks to identify every cost item associated with TTR, it would imply an equal need to identify (and quantify) every input to the system that comes from other sources – eg. Universities, unpaid staff time, research findings, access to facilities and so on. The challenge of the project is to acknowledge the complexity of the interactions within the system, capturing the key aspects of it for attribution purposes while not impeding the continuation of cross-sectoral collaboration and development.

This is not to argue against the current exercise, but rather to indicate that the innate complexities that the project team are currently grappling with should be acknowledged in the deliverables of the process – and that ABF approaches to TTR are inevitably indicative, rather than absolute measures.

One possible approach to help inform the scope of research related costs is to consider the establishment costs for hospitals that have recently become associated with medical schools –

notably transitional costs. However, while this may be informative, it should be remembered that these hospitals will have generally been teaching nurses (and possibly allied health professionals) for decades. Another avenue to potentially explore could be joint appointments (which may have entailed supports and costings), and could include university professional appointments embedded in health services. These may help to distinguish between establishment and maintenance costs.

We encourage you to report difficulties identified in quantifying aspects of TTR for ABF. That would be important information in itself and might potentially enable ABF to be applied sensibly to improve performance. This would be preferable to developing ABF arrangements that purport to reflect practice more accurately than it does, and so heighten the risk of losing capacity in crucial areas because they are not readily accounted for.

If you would like to discuss any of these comments, please contact Allan Groth from the Universities Australia secretariat on 0418 711 731.

Yours sincerely

A.M. Lansdown

Anne-Marie Lansdown

Deputy Chief Executive