Independent Health and Aged Care Pricing Authority

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

Due *(extension received)*: 5pm AEST Friday 14 June 2024

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

Response to 3.6 Teaching and training question

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?

The Office of the National Rural Health Commissioner's considerations are generally on medical workforce training and the National Rural Generalist Pathway.

The Office of the National Rural Health Commissioner concurs with the *Mid-term Review of the National Health Reform Agreement Addendum 2020-2025* that there is an inequitable allocation of teaching and training funding within block funding for small rural hospitals and other settings within local health networks (LHNs). This submission provides considerations on practical ideas that can support comprehensive data-driven processes to ensure allocation of teaching and training funding is better understood and can improve productivity and accountability to ensure LHNs support training in rural and remote settings.

Medical workforce teaching and training is intrinsically connected to public hospitals and consequently medical workforce training data is staggered across several stakeholders:

- state and territory health departments and their local health networks;
- General Practice (GP) and non-GP specialist medical colleges;
- the Australian Government's Department of Health and Aged Care through their various programs noted below; and
- government program facilitators, such as universities who oversee the Regional Training Hubs (registrars) program and Rural Clinical Schools.

Current national pricing modelling does not appropriately account for medical college and Australian Government funded training program data. It is therefore pertinent to consider data processes that follow training at an individual level. Unique Student Identifiers (USI) could be useful for the purposes of tracking individual training experiences through all contexts of post-secondary education, but it is currently not utilised in post-medical school (university) training. By tracking data at an individual level, a comprehensive understanding of cumulative costs, specific placements within LHNs and length of training time can more clearly illuminate activities that develop a specialist medical workforce within public hospitals. If USIs were

used, correlation of this data to individual specialist training pathways could also occur to improve understandings of specialty training pathway costs (e.g. GP and Rural Generalist (RG), vascular surgeon, cardio-thoracic surgeon). Training program facilitators, medical colleges, and state and territory health departments could be mandated to provide data on training to IHACPA to support data-driven processes, and if the data includes trainees' USI (therefore names not required), it can inform comprehensive analysis of medical workforce training from the initial medical school phase.

Figure 1 and *Table 1* indicate data custodians who can inform and improve the transparency of block-funded teaching and training before potential transitions to activity-based teaching and training funding.

Figure 1 Australian Government funded rural interventions across the medical training pipeline.

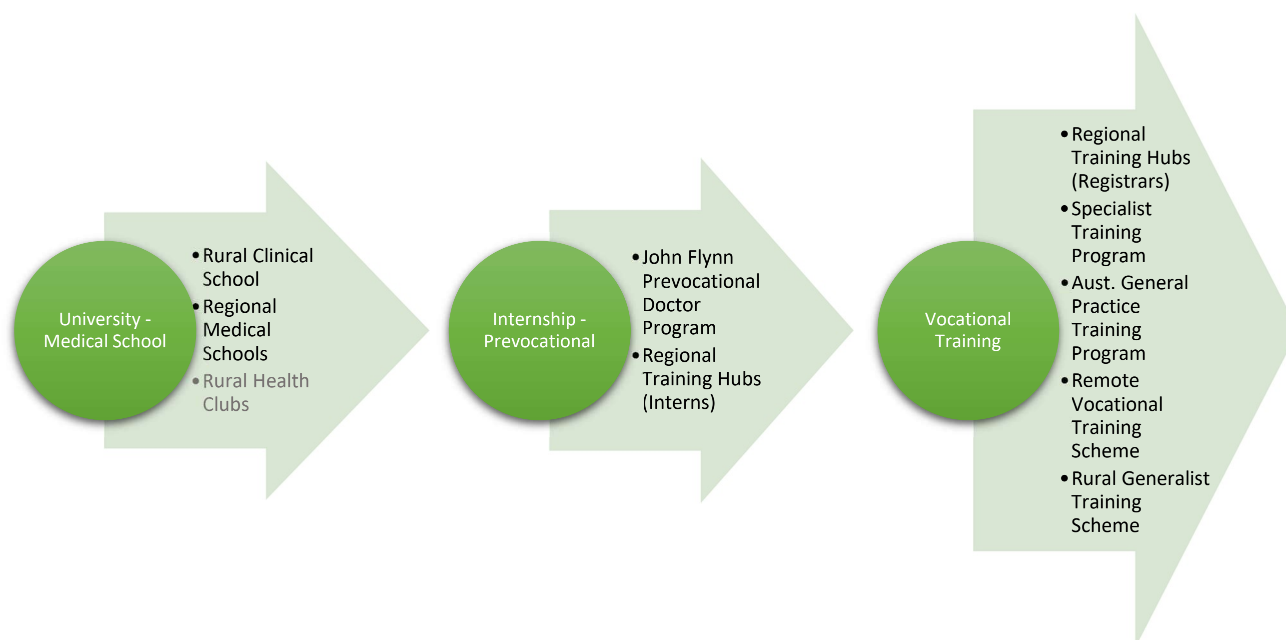

Table 1. Matrix of key Australian Government funded medical-related teaching and training programs with objectives that foster rural medical careers against relevant ATTC codes.

	Related to	ATTC
Rural Clinical Schools and Regional Medical Schools	Funded by the Australian Government to support students to study and train in regional, rural and remote communities with a curriculum rich in generalist and primary care.	C1-01
Rural Health Clubs	Funded by the Australian Government to support health students to pursue rural health careers *(data is not relevant for the Pricing Framework as it is not a training program).*	N/A
John Flynn Prevocational Doctor Program	Funded by the Australian Government to support hospital-based junior doctors (mostly rural but with limited metropolitan-based), up to post-graduate year (PGY) 5, to undertake primary care rotations.	C2-01
Regional Training Hubs (Interns)	Funded by the Australian Government to strengthen training opportunities in health services across rural and remote regions to coordinate internships in public and private hospital services.	C2-01
Regional Training Hubs (Registrars)	Funded by the Australian Government to coordinate specialist training in public and private hospitals services, and private clinics.	C3-01

	Related to	ATTC
Specialist Training Program (non-GP pathway)	Funded by the Australian Government to cover salaries of trainee specialists in training positions outside metropolitan teaching hospitals; **payments are to the specialist medical colleges** who then arrange payments to health services with the accredited training post.[1] Focus is on supporting more specialist training in regional, rural and remote settings. There are 920 training posts with an additional 100 training posts for the aforementioned Integrated Rural Training Pipeline as part of the *Regional Training Hubs (Registrars)* program.	C3-01
Australian General Practice Training Program (GP pathway)	Funded by the Australian Government for 1,500 training places per annum across metropolitan, regional, rural and remote areas. The first 12 months of training is hospital-based with both GP colleges requiring variations in rotations. For Rural Generalist trainees, some advanced skills training is hospital-based e.g. anaesthetics or obstetrics. **There is a National Consistent Payments Framework that provides support payments to supervisors, practices and registrars on this program; payments are administered by Services Australia. Some state and territory-administered health facilities in Modified Monash Model 4-7 communities have approved support payments (i.e. an exemption has been granted) for supervisors employed by their facilities through the Single Employer Model trials (related to recommendation 9 from the National Rural Generalist Pathway Advice) funded by the Australian Government.**	C3-01
Remote Vocational Training Scheme (GP pathway)	Funded by the Australian Government to support the GP registrar training in rural and remote settings.	C3-01
Rural Generalist Training Scheme (GP pathway)	Funded by the Australian Government for ≤100 rural generalist training places per annum for Fellowship with the Australian College of Rural and Remote Medicine. This scheme is a component of the National Rural Generalist Pathway.	C3-01

Teaching and training data across all relevant medical workforce training stakeholders, not just state and territory health departments, will provide a comprehensive understanding of specialist medical workforce training to cost teaching and training pricing appropriately.

[1] The *Mid-term Review* does not indicate that the initial payment is to the specialist medical college and infers that the Specialist Training Program provides payments directly to the supplying hospital, which is not the case. Page 105 from the *Mid-term Review* notes: *"Funding for these training programs is allocated to the supplying hospital (typically metropolitan or regional) rather than to the rural hospital where the trainee doctor is placed. While this funding approach may be efficient, rural hospitals have limited control over rural placements. If the supplying hospital recalls or fails to provide the doctor for their rotation/term, the rural hospital has no means to secure a replacement in the future."*

Strong investment in developing a rural medical workforce is 'front-loaded' at the medical school phase, with fewer rural training posts or rotations as medical practitioners transition to vocational training. The exception to this is GP registrar training, where the first 12 months of training must be undertaken in a hospital before training shifts to primary care and community settings, and then a return to hospital-based training may be required for particular advanced skills training (refer *Table 1* above). The predicament with intensive hospital-based training is that it fosters a culture and skillset that aligns to hospital care rather than primary and community care. It is designed for large tertiary hospitals and not for smaller hospitals or community settings within an LHN. Non-GP specialist training can be conducted in other contexts but there are challenges in gaining accreditation for non-traditional training sites because accreditation is very context focussed. It is now necessary to establish training in mixed settings to produce a fit-for-purpose medical workforce that meets national requirements (McGrail, et al., 2023; Murray & Craig, 2023). Issues with rural medical training are inferred by the Medical Board of Australia's Medical Training Survey (2023), as each year there have been low levels of self-reported regional and rural training across non-GP specialist colleges:

Table 2. MBA's Doctors in Training Survey 2023 by specialist college - responses to current vocational training setting, noting this survey represents a statistically significant proportion of specialists in training (including GPs) (MBA and AHPRA, 2023).

COLLEGE	METRO (% and approx. #)		REGIONAL (% and approx. #)		RURAL (% and approx. #)		NOT SPECIFIED	
ACD (Dermatologists)	92	44	6	3	2	1	0	0
ACEM (Emergency Medicine)	74	896	24	291	1	12	1	12
ACRRM (GP – Rural and Remote Medicine)	10	54	46	251	42	229	1	5
ACSEP (Sports Exercise)	83	25	17	5	0	0	0	0
ANZCA (Anaesthetists)	76	548	21	151	1	7	1	7
CICM (Intensive Care)	79	446	20	113	1	6	1	6
RACDS (Dental Surgeons)	95	20	5	1	0	0	0	0
RACGP (GP)	38	1,054	37	1,026	24	666	1	28
RACMA (Medical Administration)	60	49	33	27	5	4	1	1
RACP (Physicians)	82	2,709	16	529	1	33	1	33
RACS (Surgeons)	74	357	24	116	1	5	1	5
RANZCO (Ophthalmologists)	91	62	6	4	1	1	1	1
RANZCOG (Obstetrician Gynaecologists)	77	266	21	73	1	3	1	3
RANZCP (Psychiatrists)	73	672	25	230	2	18	1	9
RANZCR (Radiologists)	80	211	20	53	0	0	0	0
RCPA (Pathologists)	85	211	14	35	0	0	1	2

The Pricing Framework for Australian Public Hospital Services 2025-26 should cost rural and remote hospital (in Modified Monash Model 3-7) and relevant state and territory facilities' primary care (in Modified Monash Model 5-7 areas) teaching and training activity proportionately to recognise the complex caseloads and unique clinical settings, and reward teaching and training in the areas where the workforce is needed most.

Where the workforce trains is where they will likely remain.

The National Rural Generalist Pathway was developed after extensive sector consultation on how to improve the rural medical workforce and thus improve the health outcomes for rural Australians. The consultation resulted in 19 recommendations within the National Rural Generalist Pathway Advice for the National Rural Health Commissioner, and received funding in the 2019-20 Budget for implementation. The National Rural Generalist Pathway Advice recognised that funding inequities existed for teaching and training in rural and remote settings:

> ***Recommendation 18***
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> *Rural hospital teaching and research activity is recognised in the Hospital Funding Agreements and funding is quarantined to support and facilitate these arrangements in a nationally consistent way.*
>
> *Rural Doctors, including Rural Generalists, train in both public and private settings. To bring the benefits of teaching and training hospital/health service/practice networks to rural patients, research and training needs quarantined funding in these settings. The benchmark is the urban tertiary teaching hospital, where the contractual arrangement for salaried specialists includes funded time for patient care, research, teaching, quality improvement and professional development.*
>
> *Regional, rural and remote jurisdictional health services must be funded for, and provide, equitable access to these activities for rural medical staff, including both salaried and VMO staff. One example where this is in place is the Country Health WA 46 Medical Award, where there is a specific 20% non-clinical time allocated for rural medical practitioners.*

The National Rural Generalist Pathway Advice describes the precedent that exists for teaching, training and research funding arrangements in metropolitan hospitals where contractual arrangements explicitly fund patient care, research, teaching, quality improvement and professional development activities. There is strong evidence that the place of health professionals' training is a major influence on where they subsequently work (Larkins, et al., 2023; McGrail, et al., 2023; Murray & Craig, 2023). The Australian Government's major investments in developing a rural health workforce must be supported by quarantined funding for teaching and training in rural and remote settings (Modified Monash Model areas 3-7). The pricing framework can support this aim by incentivising teaching and training in rural and remote settings, and by acknowledging the unique clinical settings that require innovative teaching and training models.

The recent transition to college-led training in general practice has brought GP training into closer alignment to other specialty training. However, anecdotal reports from the rural medical sector suggest GP advanced skills training is de-prioritised in some hospitals[2] as funding is less lucrative for the hospitals and supervisors when the trainee is a GP registrar rather than a non-GP registrar. Given rural and remote communities' reliance on the GP workforce, training bias towards the non-GP specialist workforce must be avoided. Non-GP trainees are needed in rural and remote communities but the need for GPs in these regions is far greater. The Office of the National Rural Health Commissioner recommends IHACPA engage with the Australian Government Department of Health and Aged Care's Health Workforce Division who manage the Australian General Practice Training program, the National Rural Generalist Pathway and the Specialist Training Program to better understand this supervisor payment issue and to explore potential solutions in the *Pricing Framework*.

IHACPA would also benefit from understanding the intersections of the Australian Government funded Rural Health Multidisciplinary Training Program (comprising the aforementioned Rural Clinical Schools, University Departments of Rural Health and the Regional Training Hubs) and other programs that support the recruitment and retention of nursing, dental and allied health professionals in rural and remote communities.

[2] Further information on hospital-based skills training is available on the General Practice Registrars Australia website.

References

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