AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

12/77

Dr Tony Sherbon
Chief Executive Officer
Independent Hospital Pricing Authority
PO Box 483
DARLINGHURST NSW 1300

Dear Dr Sherbon

Thank you for providing the opportunity to comment on the Independent Hospital Pricing Authority (IHPA) 2014-15 Teaching, Training and Research Data Set Specification (TTR DSS) Consultation paper.

As members of the IHPA Teaching Training and Research Working Group (TTRWG), the AMA acknowledges that there will be further opportunities to provide input into the development of a TTR DDS. As such, the AMA offers the following preliminary comments:

- More broadly, a high quality health care system requires that every medical student and graduate be provided with a quality clinical training experience from medical school through to the completion of vocational training. While the initial TTR DSS may focus on input measures in the first instance, the ability of the data set to adequately define and measure outputs in terms of both quantity and quality must be a fundamental goal in this process.

- In developing a TTR DSS, the full spectrum of teaching and training activities in public hospitals must be taken into account. This should include, within scope, the teaching and training of undergraduate and graduate medical practitioners, nurses, allied health and other designated professionals, and higher staff development e.g. training in health service management skills.

- The majority of clinical teaching and training in public hospitals is delivered in conjunction with patient care. It is important that the DSS acknowledges the complexity of medical supervision and training and reflects the balance between service contribution and TTR.

- With regards to applying an activity based funding (ABF) model to TTR for medicine, clearly the most problematic aspect is unbundling clinical service delivery from TTR, particularly due to the significant postgraduate ‘on the job’ training that occurs. Often both clinical service delivery and TTR are delivered in the same instance at the same time. Some attempt must be made to capture this in the TTR DDS. Some methods may include but are not limited to:

    - quantifying trainee numbers by categories to provide a more granular data set which may represent clinical service delivery and TTR ratios more appropriately (see point below);

    - measuring efficiency losses due to TTR occurring, particularly in defined clinical episodes of care such that occur in outpatient clinics and operating theatre lists; and
    - 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.

- The consultants engaged to undertake the *Definitions and cost drivers project* – Paxton Partners – have pointed out the challenges associated with this, including the difficulty in unbundling clinical and TTR activity for purposes of costing and classification development and the fact there is currently no agreement on specific outputs of TTR to form basis for measuring activity.

- The AMA recommends IHPA consider the pros and cons of releasing a TTR DSS for collection before the data items are clearly defined. The immediate drawback of doing so beforehand is the inability of the data to represent a longitudinal picture if data items are added or definitions changed along the way.

- More specifically, categorisation options must differentiate between prevocational and vocational medical trainee numbers and take into account different training and supervision requirements, and their impact on service delivery, across the continuum of medical education and training and across specialities. As discussed, this is one of the hardest elements to unbundle from clinical service delivery. However the essential inefficiency in clinical service delivery associated with teaching and training, with ward rounds and procedures taking substantially more time, is undoubtedly one of the greatest cost drivers for teaching and training.

- On this basis, the prevocational trainees should be divided into PGY1, PGY2 and PGY3+ categories and vocational trainees into basic and advanced categories. Clearly more senior trainees in some specialties will provide services whilst in training. The proportions will vary depending on the specialty and the seniority of the trainee.

- It is essential that data items are included that capture clinical supervision inputs and the time both specialists and doctors in training spend in the delivery of teaching and training. Hospital rosters should account for this time to ensure clinicians can deliver these activities. Appropriate time must also be given to specialists and doctors in training to focus on their learning as well as service provision. This time should be clearly identified and should be recorded in a similar way.

- In light of the above, the AMA considers that the following data items should be included in a TTR DSS (the AMA acknowledges that this data may need to collected from sources other than jurisdictions):

    - Number of students (headcount and FTE)
    - Number of student clinical placement days
    - Number of prevocational trainees (headcount and FTE; PGY 1, PGY2, PGY3+)

- Number of vocational trainees (headcount and FTE; basic and advanced)
- Number of accredited and filled intern training places
- Number of interns successfully completing training
- Number of accredited and filled College accredited vocational training positions
- Number of vocational trainees successfully completing training
- 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.

It is important to note that none of these data items will adequately capture the essential inefficiency in service delivery related to teaching and training.

In closing, the AMA would like to draw your attention to an Outcomes statement outlining the broad principles that should underpin the development of a funding model for TTR. This statement was the result of a meeting between medical stakeholders in October last year to discuss the issue. The principles contained in this statement are relevant to the work IHPA is doing and can be found on the AMA website at https://ama.com.au/activity-based-funding-teaching-training-and-research .

The AMA looks forward to contributing to the *Definitions and cost drivers project* that will underpin much of this work, and to providing input into the 2014-15 TTR DSS as part of the TTRWG.

Yours sincerely

Professor Geoff Dobb
Federal AMA Vice President

Dr Will Milford
Chair. AMA Council of Doctors in Training

5 July 2013

gd:wm:sc