Addressing the medical training pipeline: Securing funding for teaching, training and research

18 October 2012

Summary and outcomes

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 meeting was co-chaired by Professor Geoff Dobb (Federal AMA Vice President) and Professor Justin Beilby (President, Medical Deans Australia New Zealand).

Seventeen representatives from thirteen organisations involved in medical education and training attended to discuss the feasibility of introducing activity based funding (ABF) for TTR, the potential application of such a model, and to consider broad principles that should underpin further work in this area. A list of attendees is attached.

The key outcomes from this meeting are listed below.

Planning and learning from experience

Mr Stephen McKernan and Mr Chris Mules from Health Partners Consulting Group (New Zealand) summarised the New Zealand and United Kingdom experience in implementing activity based funding for TTR. New Zealand (NZ) first implemented casemix and activity based costing in the 1980's; ABF was introduced in 1995. A separate funder (Clinical Training Agency) was established at that time. Since 2009, Health Workforce New Zealand has assumed its role as funder of post-entry clinical training, and has an expanded workforce planning and development role.

This introduced a new level of transparency and accountability to funding TT (and 'R" although this is separately funded and managed). Historically hospital management had paid little attention to the impact of clinical training on the costs of services. The ABF exercise in NZ revealed costs for clinical training were heavily concentrated in larger teaching hospitals and were more than double the 'teaching supplements' plus other specific grants being paid. Significantly, the service benefits were considerable (particularly for medical vocational programs), meaning the net cost of clinical training was much lower than previous estimates.

Funding for training and research has been unbundled in the United Kingdom (UK) since 1975 to cover both the direct and indirect costs of teaching. As in NZ, the funding for teaching and training was separated from research early on in recognition of the different funding drivers in each space. In 2009, a change of government and wider health reforms saw the creation of Health Education England (HEE). This entity is responsible for education, training, and workforce development across all professional groups and funds teaching and training across the continuum from undergraduate placements, to postgraduate to continuing professional development.

A small number of mandatory, national indicators are used to measure the performance of the health system in respect of providing a high quality teaching and training environment. This has helped to create a culture where the provision of high quality teaching and training is now core business for health providers, and explicitly linked to service quality.

The ensuing discussion focussed on the strategic intent of ABF for TTR, future accountability structures and how to monitor the performance of the health system in relation to TTR. Organisations raised a number of issues in respect of the allocation of funds for TTR via an ABF model including 1) the perception of 'winners and losers', 2) the emergence of unintended but perverse incentives to train or not to train, and 3) the capacity of an activity based model to appropriately fund the changing complexity and intensity of training across the continuum of medical training (e.g. early registrar versus advanced registrar training).

Funding models – what formulae will determine funding for TTR

The Independent Hospital Pricing Authority (IHPA) has been tasked with determining the National Efficient Price (NEP) for public hospital services, allowing for the national introduction of ABF. The National Health Reform Agreement requires IHPA to determine the cost of block funding for TTR for all health disciplines and provide advice on the feasibility of transitioning to an ABF system by 30 June 2018.

Dr Tony Sherbon, acting CEO, outlined IHPA's approach to determining a funding model for TTR. This includes setting a NEP for TTR, developing any "loadings" or "adjustments" to account for variations in prices, and specifying any classification, costing, data and modelling standards to inform a pricing framework. The NEP will be used to determine Commonwealth funding to Local Hospital Networks (LHN) for the TTR activity provided, noting that states and territories can contribute above or below the efficient price.

Participants noted that the IHPA does not 1) evaluate performance – this is the job of the National Health Performance Authority, states and territories and governing bodies, 2) determine the volume and distribution of services – this is still determined by states and territories, and 3) determine private hospital funding.

Dr Sherbon advised that IHPA is currently establishing a Teaching Training and Research Working Group (TTRWG) that will meet in February 2013. The TTRWG will consider the cost drivers (both fixed and variable) for TTR, and advise on the classification and costing of TTR activities undertaken within public hospitals. It is anticipated that there will be 12 months conceptual work undertaken with data collection to commence in 2014 allowing for the possible implementation of ABF for TTR in 2015/16 – at least 12 months earlier than the approved 2017/18 timeline.

The sustainability of TTR in a climate of fiscal restraint and a system driven by clinical activity was discussed. Organisations noted that TTR is often viewed as 'inefficient' and agreed it is important that hospitals with high TTR activity are not penalised for this activity in any funding model. The in kind contributions from clinicians involved in teaching and training must also be identified and costed.

The meeting discussed at length the importance of understanding the cost, supply and demand drivers in order to create a balanced and level playing field and a funding model that is seen to be fair and transparent. Organisations reflected that while states are free to set volume, it is vital that pricing and funding is linked to health workforce planning and projections to provide sufficient training capacity for medical graduates and trainees. The strategic link and interplay between Health and Education and the impact of the Federal Government response to the Higher Education Base Funding Review should also be considered in the development of a funding model for TTR.

While IHPA's brief is limited to public hospital settings, expanded settings will increasingly be used to provide teaching and training and must not be forgotten in any national plan to address health workforce planning.

Participants agreed **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.**

Organisations noted **the importance of a robust data set in improving the reliability of an activity based funding model for TTR** and observed it would be useful to identify the type of data that currently exists in respect of the scope and cost of teaching and training activities. All organisations were encouraged to conduct an environmental scan to identify evidence based data sources and data gaps in relation to TTR to inform future work in this area.

Finally, organisations decided it was important that any model be tested and validated to ensure its 'fit for purpose' before being rolled out at a national level. This includes ensuring the right data is collected and refining data collection processes. The meeting acknowledged the risk that once the real costs of training were known that there may be unintended

consequences that drive policy change in other areas, not necessarily for the benefit of the profession or patient care. Integration of pricing and funding work being done by IHPA with health workforce planning and projections undertaken by Health Workforce Australia will help to mitigate such risks.

A way forward – key issues that need to be resolved

A number of strategic issues were identified for further consideration as the feasibility of transitioning funding for TTR from a block grant to ABF (or another method that reflects activity volumes) is explored by the IHPA. These are summarised below.

Teaching and training (TT)

There was consensus that teaching and training should be separated in the main from research. Organisations agreed different metrics will drive the funding allocated to each component and to this end different classification systems, loadings and funding models will be required. How to separate pure research from translational research will be a key consideration. Sufficient funding must be available for health systems research into new initiatives and the translation of research into practice, including the funding of investigator initiated clinical trials.

Identifying the costs associated with research should occur in parallel with teaching and training (TT) to ensure that the two funding streams intersect. Key players in this will be the National Health and Medical Research Council and the Australian Research Council.

The concept of net cost of TT should be explored in conjunction with the concept of service benefit. Net cost calculations must take into account both the positive and negative impacts of TT on service delivery. This will be different at different points in training and the funding model for TT must 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.

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.

Classification and loading systems must acknowledge prior experience, skill set, length and intensity of training and supervision requirements. Classifications and loadings should reflect different levels of experience and variations in training requirements across the continuum of medical education and training and across specialities. Consideration should also be given to how a fixed output price might vary with the length and structure of training programs. Any model must be flexible enough to deal with variations in training in this respect.

Whether funding should follow the trainee or be allocated to the health service provider on an annual basis should be investigated. For example, in the UK every trainee has a training number and funds follow the trainee. There are pros and cons to each method and these should be systematically explored in the development of an ABF model.

There is a need for a national workforce plan. ABF for TT will apply to all health disciplines and it is inevitable that funding allocations will be prioritised according to health workforce projections and models of care. 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, distribution and community need.

TTR should be seen as core business for the health system and must be sensitive to future workforce needs. A culture of teaching and learning must be embedded in the public hospital system. Investment in teaching and training must be seen as essential to providing a quality service environment and a sustainable health workforce.

Research

Inherently different issues apply to the consideration of funding models for teaching and training compared to research. This will necessitate a separate approach and set of underlying principles for each. In developing a specific funding model for research, it will be essential that the scope of research activity is well defined. Any definition must account for both pure and translational clinical research, and facilitate the continuum of health sciences research from laboratory to clinical research to health systems research.

As the costs of research are unbundled, particular emphasis should be paid to the policy and system levers that need to be in place to incentivise and fund research that might otherwise not occur but are a health or system priority. This should include consideration of measures that will help to close the research-practice gap and account for the 'invisible' research dollars currently in the public hospital system. This must be part of a broader debate about measurement and accountability.

Monitoring the performance of the health system in relation to TTR

Professor John Horvath (former Chief Medical Officer) provided an overview of the level of Commonwealth Government funding for, and engagement in, teaching, training and research and noted that its role had changed significantly over the last ten years. He stressed the ongoing importance of aligning workforce needs and research strategies with the health care needs of the community, and emphasised the essential connection with workforce planning and the role of HWA. Questions focussed on the role of the Commonwealth in coordinating training numbers, particularly with respect to intern training numbers, the potential unintended consequences associated with the introduction of ABF for TTR, and the role of Government and national agencies in measuring performance in teaching and research.

After further consideration there was a consensus that **accountability mechanisms for funding of TTR should be underpinned by publicly reported performance indicators.**

At the conclusion of discussion, participants agreed that a national approach to intern training was highly desirable, including the implementation of a national allocation system. This would require greater national consistency and ownership at both a Commonwealth and State and Territory level.

Meeting outcomes and actions

The meeting considered a generic draft position on funding models for teaching, training and research. Participants agreed with the content of this statement in principle and asked that it be re-drafted to reflect a series of broad, high level statements, underpinned by a set of more specific principles that reflected the exchange of ideas that had occurred. This would be circulated to all participants to inform further dialogue on funding models for TTR, both internally within organisations and externally at other forums.

In summary the key strategic issues identified were:

1. **TTR should be seen as core business for the health system.**
2. **Funding models for teaching and training (TT) should be separated from research (R).**
3. **The concept of net cost of TT in conjunction with the concept of service benefit should be explored**
4. **Classification and loading systems must acknowledge prior experience, skill set, length and intensity of training and supervision requirements.**
5. **Investigation of whether funding should follow the trainee or be allocated to the health service provider on an annual basis is required.**
6. **Funding model(s) should not create disincentives to train in settings beyond public hospitals, and should not undermine other funding or training models.**
7. **There is a need for a national workforce plan.**
8. **Accountability for funding of TT and R should be underpinned by publicly reported performance indicators.**

9. **A robust data set is essential to improve the reliability of an activity based funding model for TT and R**.

In closing, Professor Dobb and Professor Beilby acknowledged the contributions of the assembled organisations and speakers. It was concluded that the meeting has led to a greater understanding of the issues relating to funding models for TTR and will be extremely useful in informing further work in this area.

Prof Geoff Dobb
Federal AMA Vice President

Prof Justin Beilby
President, Medical Deans Australia New Zealand

18 October 2012

ADDRESSING THE MEDICAL TRAINING PIPELINE: SECURING FUNDING FOR TEACHING, TRAINING AND RESEARCH

18 OCTOBER 2012
PARKROYAL MELBOURNE AIRPORT HOTEL
ARRIVAL DRIVE
MELBOURNE AIRPORT, TULLAMARINE, VIC

ATTENDANCE LIST

ORGANISATION PRESIDENTS / DELEGATES	
Prof Geoff Dobb	Australian Medical Association (AMA)
Mr Warwick Hough	Australian Medical Association (AMA)
Ms Sally Cross	Australian Medical Association (AMA)
Dr William Milford	Australian Medical Association Council of Doctors in Training (AMACDT)
Mr James Churchill	Australian Medical Students Association (AMSA)
Dr Antony Sara	Australian Salaried Medical Officers Federation (ASMOF)
Dr Roger Boyd	Committee of Presidents of Medical Colleges (CPMC)
Dr Susannah Ahern	Confederation of Postgraduate Medical Councils (CPMEC)
Mr Alan Mackay	Group of Eight (Go8)
Mr Ben Wallace	Health Workforce Australia (HWA)
Prof Justin Beilby	Medical Deans Australia & New Zealand (MDANZ)
Ms Mary Solomon	Medical Deans Australia & New Zealand (MDANZ)
Dr Andrew Gosbell	The Australasian College of Emergency Medicine (ACEM)
Prof John Wilson	The Royal Australasian College of Physicians (RACP)
SPEAKERS	
Prof John Horvath, AO	Department of Health & Ageing (DoHA)
Mr Stephen McKernan	Health Partners Consulting Group (NZ)
Mr Chris Mules	Health Partners Consulting Group (NZ)
Dr Tony Sherbon	Independent Hospital Pricing Authority (IHPA)
APOLOGIES	
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Dr Dianne Watson	National Health Performance Authority (NHPA)
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