Submission to IHPA on Development of the Australian Teaching and Training Classification – Mater Misericordiae Ltd, Brisbane

1. **Are the current variables included in the ATTC Version 1.0 relevant to clinicians, health service managers, and other stakeholders?**

On face value it appears reasonable and relevant to the stakeholders to have (i) Year of training (ii) Area of Clinical Focus (iii) Level of qualifying education certification as variables. However, this needs to be weighted with consideration for health services in regional and remote areas too. Clinical Activity based funding tends to favour large metropolitan sites which can manage high turnover, high revenue generating admissions, but may disadvantage rural or regional communities where it costs much more to deliver the same service. We think this would have a similar impact in FTE funding of education and training i.e. large metropolitan hospitals with >7000 staff will receive much more revenue while small facilities with < 300 trainees have much less scope to deliver the same expectation of direct educational access. Startup costs for educational delivery in these areas are usually higher; this may detract from potential to recruit and train in regional areas. Our experience of educational grant funding is that this tries to balance this inequity - with grants often being prioritised to rural or remote areas.

2. **Are there any further considerations in relation to the proposed structure?**

Consideration should be given to (i) Duration of Clinical Placement Experience (as some education providers differ in their hours and some students require remedial (ii) Model of Clinical Placement (as some education providers differ in their level of resourcing of supervision whilst students are on clinical placement e.g. in nursing some providers have supervisor to student ratios of 1:10 whilst some are at 1:40-50 – which shifts an unreasonable and inequitable burden of assessment for competence into clinicians in the health setting who are also delivering care to patients. Additionally, consideration should be given to the different Allied Health groups. It may be that it requires defining them as significant variation exist in their training requirements.

3. **Are there other variables which should be considered in future versions of the ATTC?**

It's worth noting the emergence of dual degree qualifications as well e.g. (nursing and midwifery) – and the need to incorporate that into Table 1 (End Classes) or to classify it appropriately. It would also be worthwhile capturing the days of clinical placements, how many academic appointments we have in each professional group and any funded academic positions.

4. **What supporting material would be beneficial for the ATTC?**

Agree with the development of a User Manual and ATTC Grouper software, fact sheets, articles in the newsletters of peak bodies and educational institutions, an infographic, and/or an animation. We especially like the concept of animation – an easy to understand process delivered in an engaging way will be necessary for engagement. It would be useful to clarify if there would be a central portal for collection and a central electronic site that has all the support material there as opposed to current state where excel spreadsheets are sent electronically – and there's a hope that it is then recorded accurately. The governance (and accuracy) of this process of recording data is necessary due to the funding implications if there's a missed stroke key from human error. Additionally, information about the formulas for calculating the data in case it is required for a report and the User Manual should include clear definitions of terms used.

5. What communication avenues and methods should IHPA consider in order to inform and engage stakeholders of the ATTC and future ABF for teaching and training?

Correspondence (via email) to the stated stakeholder engagement group will be necessary, however we would suggest direct correspondence to the executive group in charge of running the hospitals as well. This would assist in ensuring communication is disseminated to all hospitals (metro, public and private). Placing the communique in key newsletters that are disseminated within these key stakeholder groups will be helpful. Better to over-communicate on this one given funding implications. Include specific Education Divisions/ Departments affiliated or included in Health Services, e.g. Mater Education. All information should be available on a centralised website for access.

6. Are there particular aspects or areas of the ATTC that should be prioritised in its development, or aspects that should be developed at a later stage?

It is interesting to note the ATTC was developed using only direct and indirect costs. Whilst the explanation of removing embedded activities seems reasonable, we do require oversight of the overheads section and note this is not included in this version of the consultation paper. Overhead costing for teaching and training is significant and must be included (it would be worthwhile to have visibility and hopefully input) of the version 4 of the NHCDC AHPCS for this reason). Even if not included, it is worth building something to capture the data for at the very least - benchmarking purposes, as it has a significant impact on training cost. Additionally, as a consultation paper, this document is difficult to read. Perhaps there is an opportunity for streamlining with plain language, better use of visual information to simplify communication of information, and electronic expander scroll over functions for cumbersome acronyms for the next phase?

7. Are there any further considerations that should be taken into account when developing the ATTC?

Whilst the scope of this paper outlines the funding under an ABF arrangement (and therefore public hospitals) –this consultation period is a great opportunity to highlight the disparity in lack of support for the private sector that shoulders a significant burden in training the national health workforce. The 2017 'Education and training in the private hospital sector' report, produced by the Australian Private Hospitals Association (APHA) and Catholic Health Australia (CHA) shows the **private sector's investment** in training doctors, nurses and allied health workers has increased to $167 million from $30 million a decade ago. In preparing this report there were challenges to collect the data for the APHA/CHA report as these aren't captured in most cases and when it is, doesn't provide an accurate reflection. There should be one repository for training affiliated with a Health Service affiliated with training and education partners.