Consultation Paper on the Development of the Australian Teaching and Training Classification

Queensland Submission to the Independent Hospital Pricing Authority

Background

The Independent Hospital Pricing Authority (IHPA) is seeking feedback from stakeholders on the *Development of the Australian Teaching and Training Classification*, released on 10 August 2017 for public feedback.

This public consultation paper seeks stakeholders' views on the proposed structure and data items for inclusion for the Australian Teaching and Training Classification (ATTC). The consultation paper describes the work undertaken to date to design a nationally consistent method of classifying teaching and training activities and the associated costs, provides details of the statistical data analysis undertaken and consultation processes used.[1]

Directorate Position

Queensland welcomes the opportunity to provide feedback in relation to the ATTC and acknowledges the progress the IHPA has made developing the ATTC. Queensland actively supports this initiative, which was demonstrated by 13 of the 19 participating facilities in the 2015 teaching and training costing study were Queensland hospitals.

Queensland has established a jurisdictional working group to gather feedback on the ATTC, consider the impact of the new classification, coordinate recommendations to positively influence development of the ATTC and work towards implementing a jurisdictional data collection to support the classification.

Queensland recognises that teaching and training activities comprise a key pillar of workforce advancement with strong links to attraction and retention within the healthcare system. Queensland is strongly supportive of teaching and training across all domains within the jurisdiction, and any mechanism in which qualification is linked with clinical activity to support personnel development.

Queensland however has reservations regarding the ATTC development process. Product costing principles dictate that classifications should be derived from descriptively homogenous and economically homogenous groupings through available variables and cost data, however the ATTC products have been defined prior to the availability of cost data. This methodology may presuppose the classification outcomes thus affecting the overall quality of the ATTC. Robust classification healthcare systems such as Diagnosis Related Groups (DRGs) were developed from cost data, not prematurely and in the absence of appropriate grouping metrics.

Despite the aforementioned concerns, Queensland maintains its commitment to support the IHPA to develop the ATTC. At this time however, Queensland cannot endorse the ATTC pending the completion and validation of a costing study endorsed by all jurisdictions.

The following feedback is from the Queensland Department of Health, unless identified as being from a specific Queensland stakeholder.

[1] https://www.ihpa.gov.au/consultation/current-consultations/development-of-the-australian-teaching-and-training-classification

4. ATTC Version 1.0

Variables for consideration in future version of the ATTC

Consultation Questions:

1. Are the current variables included in the ATTC Version 1.0 relevant to clinicians, health service managers, and other stakeholders?
2. Are there any further considerations in relation to the proposed structure?
3. Are there other variables which should be considered in future versions of the ATTC?

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

Feedback received from Queensland stakeholders consistently raised concerns regarding the use of Full-Time Equivalents (FTE) as the unit of measure. The use of staff FTE as the unit of activity will not factor in part-time workers. For example, two nursing staff working 0.5 FTE amount to one FTE however as each staff member is entitled to their own component of teaching and training, this should equate to two units of activity. Queensland recommends that the IHPA consider a more reliable unit of measure such as headcount.

Noting the above concerns regarding the proposed unit of measure, if FTE is confirmed as the unit of activity for the ATTC, a clear definition must be established to ensure accurate and consistent data is reported across jurisdictions. The consultation paper states FTE of trainee, not FTE of trainee per year, or FTE of trainee per term, or FTE of trainee per week and there is obviously a significant difference between these measures. If the measure is FTE per trainee for their whole training, this could produce excessive high results. It should also be noted that an FTE can vary depending on the definition applied, therefore Queensland recommends that an unambiguous measure such as headcount or direct hours would be a more appropriate indicator for the collection. It would be appropriate to consider both measures be reported as part of the collection.

Queensland also recommends that definitions be included for key data variables such as “Profession”, “Training Stage” and “Vocational”. Queensland stakeholders have queried whether “Profession” refers to those that lead to registration only.

The “Profession” category should also be expanded to include a category titled “Other”. Queensland stakeholders noted that some professions are not included in the available list, an example of this are Physician Assistants. Physician assistants are trained in medical diagnosis and therapeutic reasoning and work under delegation of a supervising medical practitioner. James Cook University is the only university in Australia offering the course and there is only small number of enrolments / graduates. The course is a bachelor degree that includes clinical placements in a range of areas in the public and private health care sectors. Physician Assistants are not doctors, nor are they allied health professionals.

The following comments relate to the current variables:

- The aggregated version of the ATTC is more readily available than the previously proposed sub-specialty model. The significance of collecting at the sub-specialty level would need to be tested as to the cost benefit of collecting at this level. The consultation paper mentions the option of expanding the

ATTC to include the "Year of Training". Currently this is not collected in Queensland and it would be very difficult to collect and misleading due to the fact that undergraduate and postgraduate students could be performing the same clinical placement for allied health and nursing. That is, they would have different years of training yet undertaking the same clinical placement requirements.

- "Area of Clinical Focus" is also stated as an option. Currently area of clinical focus is not collected at the level beyond the Australian Institute of Health and Welfare (AIHW) Metadata Online Registry (METeOR) defined level. Collecting at this level for medical practitioners is very difficult due to vocational training moving between training sub-specialties within the same colleges, for example College of Physicians or the increased uptake of dual sub-specialties.
- "Level of Qualifying Education Certification" is another option mentioned. The level of education leading to certification may vary for the same ends (i.e being qualified to practice). For some health professionals (particularly allied health) there are numerous pathways to attain the necessary qualifications to practice (e.g. degree, graduate entry masters or a postgraduate masters). All of the pathways are likely to be undertaking similar clinical placements over the course of their training, making the collection of Level of Qualifying Education Certification misleading as to the cost of delivery.

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

Further consideration is required in relation to the reporting specifications of the time series for data collection. The IHPA data collections align with financial years to support funding allocations, however information currently available at the hospital level is recorded by calendar year. Queensland acknowledges that the IHPA can apply adjustments to align the periods however there also needs to be verification with data held by the universities. In a recent data capture, Queensland Health staff found that the university level data was significantly different to the data collection from the hospitals. The university level data may align to other time series variables such as, the academic year (February to January) or semesters.

The "Stage of Training" of the classification structure does not map to the medical training program in Queensland, nor does it adequately account for the variation of training needs across the clinical specialties. In particular, the "Stage of Training" of "New Graduate" covers a significant number of trainees that would be better grouped into the term "Prevocational". "Prevocational" also represents overseas-trained doctors working within the health system; this group is particularly important in rural Australia. Queensland recommends that as a minimum the "Stage of Training" for medical should be as follows:

- Pre-entry Students
- New Graduates
- Prevocational (rotational)
- Vocational training or non-rotating prevocational

Although not included in the first version of the ATTC, the "Area of Clinical Focus" (or "Specialty") is a proposed data element of the Hospital Teaching, Training and Research Activities National Best Endeavours Data Set (HTTRA NBEDS). Nursing and midwifery staff have noted that the definition states: *"for nursing, specialty generally only applied to the postgraduate / vocational stage of training, where trainees undertake training in order to obtain a qualification for an advanced scope of practice"*. Considering this, is "advanced scope of practice" defined as per the Australian Health Practitioner Regulation Agency (AHPRA) definitions? If so, this is very limiting to the nursing and midwifery education model. This would exclude training such as Rural and Remote Isolated Practice, Immunisation, Sexual

Health and Transition to Practice in specialisations including Mental Health, Peri-operative, Intensive Care, Special Care, Paediatrics (both General and Paediatric Intensive Care). Hospitals and Health Services (HHSs) invest significant funds into developing the nursing workforce through these programs.

Also in relation to the "Area of Clinical Focus" data element, Queensland Health's Workforce Strategy Unit requested clarification regarding the definition of an "Aboriginal and Torres Strait Islander Health Worker". Aboriginal and Torres Strait Islander Health Workers are part of the overall Aboriginal and Torres Strait Islander health workforce, and are different from Aboriginal and Torres Strait Islander Health Practitioners (ATSIHP). ATSIHPs are registered with the National Registration and Accreditation Scheme administered by AHPRA and have different educational requirements from Aboriginal and Torres Strait Islander health workers. There is an educational requirement for a higher number of clinical placement hours for ATSIHPs.

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

Queensland recommends that the IHPA reconsider decisions regarding exclusions to the classification. Queensland stakeholders provided feedback in relation to teaching and training activity types and cost components, which if included, would improve the scope of the collection and public acceptance.

Queensland stakeholders overwhelmingly responded that for the classification to be accepted, that embedded teaching and training must be incorporated to truly capture the cost of delivering teaching and training.

The consultation paper states that embedded costs accounted for nearly 80% of total teaching and training costs based on data collected during the costing study, which when excluded severely limits the scope of teaching and training used to develop the classification. The consultation paper also states that the cost of embedded teaching and training is already priced as part of the other Activity Based Funding (ABF) models, however this does not consider the specific cost of trainees to individual episodes of care.

Metro North HHS also raised the following concerns regarding the costing study:

- The consultation paper discusses that clinician surveys were employed to collect embedded teaching and training costs. A research study undertaken at Redcliffe Hospital by Dr Craig Margetts, Dr Joel Dulhunty, Dr Arlena Kunzel and Adrian Boddice entitled "Embedded Teaching Pilot Validation Study" demonstrated that this is an unreliable method to collect this data.
- The consultation paper also discusses that data was collected from May to October 2015; this excludes the most resource intensive period for teaching and training (January to April) which is of significant concern. Furthermore, whilst opportunities to submit retrospective data were made available and acted upon, the consultants that managed the study excluded any retrospective information submitted by the HHS for Tranche 1 of the costing study.

The consultation paper also states that overhead costs were excluded from the exploratory data analysis and classification data modelling. Queensland stakeholders consider this of concern and believe that these costs should have been included in the development of the classification.

Queensland stakeholders also provided a range of additional variables that the IHPA should consider for future iterations of the ATTC, these include:

- The rurality of the hospital or opportunity to attract qualified senior staff specialists for training; both of these factors may influence the cost of delivery of teaching and training.

- The facility location is a collected variable but consideration should be given to a cohort analysis of different sized training facilities, as it is likely that the size of a facility directly relates to the cost of delivery of training. An economy of scale may be obtained in large teaching hospitals as opposed to smaller regional facilities.
- As well as the size of the hospital, other variables such as the volume of the clinical workforce, strength of association with universities and number of students enrolled at the universities could be explored. Undoubtedly, there will likely be inter-dependencies (collinearities and interactions) between these variables but the most significant ones could be determined statistically; a good method would be to use some form of penalised regression.
- For specific staff groups, teaching and training will be performed outside of core business hours. It would be worthwhile measuring the volume of after-hours training due to the inherent additional cost of service delivery. Nursing stakeholders have advised that it is commonplace for training to support mandatory competencies to be conducted after-hours to enable night-shift staff to meet professional requirements.
- Other variables, which have not been taken into account but are associated with clinical activity and the performance within the healthcare system, include that of ancillary health and support services. It is considered a risk that large groups of staff such as operational and administrative staff are currently excluded from the ATTC. By omitting these staff groups, staff involved in maintaining competency standards may also be excluded. Based on the current ATTC criteria, the majority of post-registration staff not undertaking additional advanced qualifications will also not be eligible for reporting. Teaching and training for these staff groups is also pivotal to productivity and the ATTC needs to consider this aspect as part of the classification.
- Queensland also recommends that the IHPA include International Medical Graduates (IMG) in future iterations of the ATTC. Although Queensland participants included IMGs in the costing study, information for this staff group was removed for the classification development. There is a cost difference associated with Australian and overseas trained graduates which supports a distinction between these trainee groups in the ATTC.
- The “Profession” variable does not provide a clear definition of what is included in allied health. Each allied health profession is a profession in its own right, with different training and qualifications. The current structure which suggests that for allied health, “specialty refers to the specific allied health profession” is misleading. It does not allow for the inclusion of the postgraduate or vocational training stage of training (as defined for nursing). While limited allied health postgraduate training currently occurs through clinical placements, this has the potential to grow in the future.
- The potential sub-specialties which have previously been proposed for the 2018-19 NBEDS were misleading, providing granularity for the Physiotherapy profession but no “sub-specialisation” for other allied health professions. The sub-specialisations provided for Medical Imaging are all separate professions and should be acknowledged at the profession level.
- Queensland also recommends that the IHPA consider extending the list of oral health professions either as sub-specialisations under “Oral health” (within the allied health “Profession”) or preferably, as standalone “Areas of Clinical Focus” under “Dentistry”. These are distinct professions within the dental / oral health sector and within Queensland Health, Dentists and Oral Health Therapists represent the most common trainee groups. Aside from Dentists, the Dental Board of Australia recognises the following dental practitioners:
  - Dental Specialist (registered practitioner with post-graduate qualification required)
  - Dental Therapists (registered practitioner with bachelor qualification required)

  - Oral Health Therapists (registered practitioner with bachelor qualification required)
  - Dental Hygienists (registered practitioner with advanced diploma or bachelor qualification required)
  - Dental Prosthetists (registered practitioner with bachelor qualification required)

Queensland Health also provide support for trainee programs for non-registered practitioners including:

  - Dental Technicians (not registered practitioner but bachelor or diploma qualification required)
  - Dental Assistants (not registered practitioner but certification recommended)

- Feedback from medical stakeholders suggested that the IHPA should refine the "Training Stage" in future versions of the ATTC. The level of support that a new graduate requires varies greatly depending on whether the new graduate is of a basic or advanced competency. New graduates newly entering the hospital setting require significantly more support than a new graduate well into their training. Once deemed "advanced" a new graduate requires less direct management and can operate efficiently and independently (as appropriate).
- The ATTC details extensive activity collection however there is no reference to cost; it is imperative that activity information is linked to cost to analyse the provision of service.

5. Next steps and further opportunities to participate

Finalise ATTC Version 1.0

Consultation Questions:

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

What supporting material would be beneficial for the ATTC?

Queensland stakeholders provided the following feedback regarding supporting material that would be beneficial for the ATTC:

- The (key) definitions should be included in the document via a summary of the HTTRA NBEDS / METeOR definitions or through references for the technical specifications. Feedback from Queensland stakeholders was that a user should be able to review definitions in the main document. The IHPA should also consider including more definitions and examples of the data elements.
- Procedural and supporting documentation should also be included to guide data custodians in the collection of the relevant data, with clear statements as to the roles and responsibilities of individual organisations (for example, medical schools, public hospitals, colleges etc.).
- It is also recommended that data templates be developed or uniform reporting systems be established to ensure consistency of information.
- Medical staff raised concerns regarding the limited supporting material currently available to adequately quantify and describe teaching and training as it occurs within the range of public hospital facilities. It was suggested that it may be worthwhile to engage a consultancy that can assist organisations in both the definition of variables and the collection of data.

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?

Queensland supports the IHPA in establishing a communication strategy to inform stakeholders of the collection and provide insight into how it will be operationalised and tested in hospitals and appropriate healthcare settings.

Feedback from Queensland stakeholders suggested the following information dissemination mechanisms should be considered by the IHPA:

- Cross-section fora to share information and collectively identify challenges and solutions
- Communication with jurisdictional representatives who in turn will liaise with local level providers
- On-site fora in which interested stakeholders can engage and contribute in respect to ABF for teaching and training; these may include Clinical Councils or similar
- Factsheets and simple messaging
- On-line training tools similar to animated films currently available on the IHPA website

Development of future iterations of the ATTC

Consultation Questions:

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

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?

Queensland recommends that the IHPA consider a parallel data collection process to verify the data collected at the jurisdictional and hospital level. Queensland recently undertook a process to validate information collected by HHSs with university data. The results showed variances between the collections that raised queries regarding which institute would be best positioned to generate accurate information for statistical analysis and reporting.

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

A factor that the IHPA should consider in relation to public acceptance of the classification is the noted limitation whereby no hospitals from New South Wales or Victoria were included in the costing study. Input from these jurisdictions will need to be sought for the classification to be implemented nationally.

Queensland provided feedback to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2018-19 stating that the IHPA should elaborate the benefits of the ATTC in the consultation paper. There are benefits listed in the public consultation document, however there is no evidence supporting these statements. Queensland suggested that the IHPA expand the list of benefits to

mitigate concerns likely to be raised by HHS and jurisdictions as part of this public consultation process. The outstanding concerns raised by Queensland stakeholders include:

- Has there been any consideration regarding how jurisdictions and facilities would implement an output-based approach as it is acknowledged that managing an activity based system is more expensive than a grant-based approach. Where will the funding come from in order to monitor and manage this?
- Activity based models are designed to promote efficiency and provide the opportunity for hospitals / HHSs to monitor utilisation. It is unclear how an activity based model for teaching and training will achieve this. The number of participants, duration of education sessions and expertise of training staff cannot be altered; any reduction of training / education may compromise patient safety and quality. The appropriateness of any activity based model is questionable if facilities / jurisdictions cannot increase efficiency of services delivered.
- It has been suggested that there is little benefit in the collection for jurisdictions. The data collection process may be a significant cost impost for states and facilities and can only lead to increased complexity with little likelihood of additional funding. If no additional funding is available, there can be no expansion in teaching and training and with the additional cost of gathering, collating and reporting the data; it is more likely that funds will need to be redirected from core teaching and training activities to support the collection at the expense of patient care.
- The ATTC must demonstrate clear benefits for teaching and training activities to justify focussing on a relatively small portion of the funding.

Queensland stakeholders have also suggested that to develop the ATTC further, an expert advisory group that comprises individuals responsible for the teaching and training within individual public hospital organisations should be convened with the potential of smaller working groups to provide informed and contextualised advice.

A recurring theme from stakeholders that have reviewed the consultation paper is that universities would be better placed to collect information in relation to students. As previously mentioned Queensland Health staff recently audited HHS and university data and noted the student numbers were different between the collections. Universities maintain student registers and can extrapolate known educational requirements for professional streams to crosscheck student placement hours, thus validating the reported information. Queensland recommends that the IHPA investigate whether universities would be better placed to collect student placement information. It is further recommended that consultation occur with junior medical officer accreditation agencies throughout jurisdictions in addition to discussion with accreditation bodies of the various colleges in medicine and nursing be undertaken.

The “Pricing teaching and training activities using the ATTC” section of the document provides details of the future direction and states that the IHPA will continue to block fund teaching and training as the classification system evolves. Queensland recommends that the IHPA consider utilising a blended approach, with some purpose specific block funding left in place until confidence and clarity of the impact of an ABF model is understood. Any ABF model for teaching and training should also be shadowed for at least one financial year prior to implementation.

Although not specifically related to the ATTC methodology, Queensland stakeholders requested confirmation that the FTE listed in appendix C are correct, particularly those reported for midwifery. Given that only 19 sites nationally participated in the study, if the reported FTE are correct there is concern that the underlying data may not be robust enough to support the development of a national classification for teaching and training.