



The Royal Australasian
College of Physicians

RACP submission to public consultation paper: Teaching, Training and Research Costing Study

Executive summary

The Royal Australasian College of Physicians (RACP) welcomes this opportunity to provide feedback to the Independent Hospital Pricing Authority (IHPA) on the public consultation paper for the Teaching, Training and Research (TTR) costing study.

Our recommendations

1. Full details of the TTR activities which IHPA plans to measure and the data sources used must be provided to allow for proper consideration and effective feedback by stakeholders.
2. The qualitative methods that will be applied in proposed site consultations must be specified.
3. Site consultations must be sufficient to ensure an accurate representation that captures and reflects the diversity of organisations delivering TTR across Australia and the diversity of their locations and contexts, including rurality and population health needs.
4. Consultations must include academic clinicians with long-standing and recognised experience in teaching and/or research.
5. The following considerations must apply when determining an effective approach to costing embedded teaching and training (T&T):
 - a. Use of representative data and the appropriate evidence base, ensuring the ability to account for variation between sites and specialties, and employing a time and motion study coupled with focus group and interview data.
 - b. Accounting for the increased time commitments required to ensure the well-documented evidence base needed to support T&T, driven by changes in requirements as postgraduate medical education becomes more formalised, robust and accountable.
 - c. Accounting for changes in training approaches and settings, including the increased use of simulation training, and the flexibility to account for future changes that should be expected within the timeframe for this costing model.
 - d. Accounting for seasonality in hospital activities, preferably through a year-long study.

6. Embedded research costs must be taken into account in the proposed costing methodology. Not doing so means, among other things, that:
 - a. An entire category of research, namely health services and health systems research, particularly in the study of alternative models of care and clinical redesign, would not be appropriately recognised.
 - b. The contribution made by hospitals to more 'traditional' clinical research would be ignored.
7. Time spent by staff in writing research grant applications should be included when estimating research costs, irrespective of whether these applications are ultimately successful. There is a significant opportunity cost to this time given the low NHMRC success rates due to the high number of applications and the limitations of the competitive grant funding system.
8. The methodology for research costs should take account of the interface at a hospital level between industry, institute and university funded research. Costs would be expected to be variable from site to site due to the different local arrangements.

Introduction

The Royal Australasian College of Physicians (RACP) welcomes this opportunity to provide feedback to the Independent Hospital Pricing Authority (IHPA) on its public consultation paper for the proposed Teaching, Training and Research costing study.

We believe that it is vital that this costing study is undertaken appropriately, so that the work effectively delivers on its objectives. Teaching, training and research (TTR) in hospitals has significant public benefits in the form of delivering a highly-trained workforce and a healthcare system that is able to research and adopt improvements in healthcare interventions and models of care. However there has been a longstanding absence of a clear approach to ensure the costs of delivering these benefits are appropriately recognised and 'ring-fenced'. In a system tasked to deliver increasing levels of care to increasing numbers of patients, the pressures on those who deliver TTR within hospital is not surprisingly also increasing. Medical education is a constantly developing and changing field. Its requirements are growing as medical specialist training becomes more formalised, robust and accountable. This in turn requires a greater time commitment from the supervisors, mentors, education heads and lead researchers; at times conflicting with the need for them to see more patients and deliver more health services.

This study must take the opportunity for the costs of TTR to be considered, but this must be done in a framework that fully recognises and values the benefits of TTR to the community, and within a model that accurately and comprehensively measures all the costs involved. The model must recognise that the vast majority of TTR activities is embedded with patient care, and develop an appropriate way of measuring and costing this. In addition, it must recognise the increased complexity of the environments within which TTR is undertaken, and ensure that the funding of public teaching hospitals adequately takes into account the additional workload required for high quality and effective TTR.

On p. 6 of its consultation paper, IHPA states that:

The overarching objective of the project is to undertake a TTR cost and activity data collection across a representative sample of Australian hospitals, and thereby develop a costed data file to inform the development of a TTR classification.

The costing study should:

- *Improve our national understanding of the similarities and differences in TTR provision between different hospitals, states and territories and geographic locations;*
- *Improve participating sites' understanding of the nature and costs of TTR delivery; and*
- *Ultimately provide a tool for hospitals to use for planning purposes and states and territories to use in their funding systems.*

We commend these stated objectives. In particular, the first two dot points highlighted above are important and if done well, would add considerably to the ability to have a meaningful national conversation on the determinants of costing for TTR performed in public hospitals. The third highlighted dot point (to provide a tool for hospitals for planning purposes and States for funding purposes) should be the main focus of the inquiry. This would return significant policy dividends, particularly as the result could be used to better inform jurisdictions, which currently take very different approaches.

The consultation paper at p. 10 defines the deliverables of this costing study as follows:

- *A comprehensive data file containing six months of costed data that is suitable for classification development. Separate data files will be provided for T&T and research;*
- *A descriptive and exploratory analysis of the costed data file; and*
- *A final report which includes final methodologies, high level analytical results and considerations relevant to IHPA's future work program in relation to TTR. This report will be made publicly available.*

Subject to one significant caveat (we believe the data file should contain data over 12 months rather than six, for reasons discussed further below) we urge IHPA to ensure its model is focused on achieving these deliverables. Compromising on these would risk delivering an outcome that could provide an inaccurate costing model, which would have significant short and long-term implications; both for the future health workforce and for the delivery of patient care within public teaching hospitals,

Lack of specificity in the consultation paper

The consultation paper is requesting input on data items even though a full list of the current planned items is not provided. Instead the paper provides examples, some of which have omissions of real concern such as:

- the development of curricula and accreditation processes under teaching and training;
- participating in reviewing papers for publication in peer reviewed journals and
- the participation by senior registrars in research under supervision.

However, it is difficult to provide constructive feedback on illustrated examples. Therefore we recommend that IHPA provide full details of which TTR activities it plans to measure and which data sources will be used. Parties making a submission would then be able to 'tick off' this list and make further recommendations if there are any missing items. The consultation paper should also specify the qualitative methods that will be applied to yield information from these consultations and expand its site consultations to include academic clinicians with track-records in teaching and/or research.

The importance of embedded teaching and training to overall teaching and training

Medical specialist training is delivered in workplace settings under supervision, and follows the educational 70:20:10 model.¹ This is a model where the vast majority – probably around 90 per cent - of T&T is likely to be embedded, based on the following components:

- **70 per cent workplace-based learning.** The majority of trainee learning is gained from on the job experiences, undertaking tasks and problem solving in the nature of performing one's job. This is essentially experiential learning. (*embedded*)

¹ Lombardo, M., Eichinger, R. The Career Architect Development Planner 3rd Edition (The Leadership Architect Suite). 2000.

- **20 per cent learning from others.** Trainees will also learn and develop through feedback and working with others - this can include observing role models including their supervisor, peers, and other health professionals. (*embedded*)
- **10 per cent formal learning.** In addition, trainees will learn to a lesser extent from formal learning experiences such as through attending courses and accessing online learning resources. (*direct*)

Currently the majority (but not all, as argued below) of the costs of embedded T&T are attributed to unit DRG costs. However, if IHPA decides to take account of the costs of embedded T&T it must take account of numerous complexities which are discussed below. Failure to account for these complexities could result in a costing study that fails to understand or reflect nine tenths of the T&T performed in hospitals.

Complexities associated with capturing the costs of embedded teaching and training

The consultation paper defines the embedded costs as T&T activities that occur in conjunction with clinical service delivery. It correctly identifies three sources of increased costs due to hospitals supporting embedded T&T:

- Trainees or trainers not actively participating in clinical service delivery and essentially observing the practice of patient care being delivered;
- Patient care activities take longer to conduct whilst delivering T&T; and
- Increased use of consumables.

There are numerous complexities associated with capturing the costs of embedded T&T and the RACP has identified the following challenges that need addressing. It should be noted that teaching is more typically associated with activities not involved in direct patient care, whereas training is more embedded and therefore subject to more complexity so these considerations are particularly applicable to training costs.

1. **Ensuring that the study is based on representative data and is evidence based.** There is a serious risk in relying on data captured in clinical systems (as this is often incomplete) or from real time data collection (which is dependent on compliance by participating clinicians) insofar as the resulting data collected may not be representative. There is also likely to be significant variation in the costs of delivering T&T not only across sites and hospitals (e.g. metropolitan hospitals vs rural hospitals which have significant difficulties in recruiting sufficient numbers of teaching and supervising clinicians²) but also across specialties. Special consideration may also need to apply to reflect special training needs and priorities (for instance indigenous health workforce development). Thus the costing methodology and data collected must be appropriately customised and categorised to reflect these possible variations. The representativeness of the data collected will be integral to its accuracy and the overall rigour of the data collection process. Acceptable methodologies may include time and motion studies coupled with focus group and interview data.
2. **Taking account of changes in regulatory requirements** Medical education requirements are increasing as specialist training becomes more formalised, robust and accountable. This is in line with the expectations of the College's accrediting bodies (AMC and MBA) and the community that the College's training programs benchmark positively with national and international best practice. This increased rigor and formalisation generally correlates with

² Input from consulted Fellow.

increased time commitments for supervisors and trainees, particularly in increased supervisor time needed to document T&T activities. Costing methodologies will therefore need to reflect the likelihood that these costs will increase, not decrease in the future. Time spent on this activity is not covered in unit DRG costs which relate to service delivery, nor do they neatly fall under the direct or indirect T&T categories – they are a form of embedded T&T cost.

3. **Taking account of expanded training settings.** Physician training sites are expanding to include non-traditional venues and non-traditional methods. One non-traditional method which may gain increased future prominence is simulation training which could be a potentially higher cost model. These future changes in training models and venues also mean that there may be changes in the current allocation of embedded T&T activities. This is another reason why properly costing embedded T&T may require either adjusting for possible changes in future or ongoing and regular updating of costing data, possibly from a range of T&T venues.
4. **Taking account of seasonality in hospital activities.** There is significant variance in both hospital and T&T activities across the year. For instance trainee orientation is concentrated at the beginning of the calendar year, and there is an increased clinical load in winter. There is also seasonality associated with meeting National Safety and Quality Health Service Standards which are directly associated with training, as activity and time commitments increase in direct proportion to the approaching accreditation. Therefore it is vital that the study be conducted over a full year to account for seasonal factors, rather than the six month study being proposed.

Notable omissions in capturing the costs of research

The consultation paper fails to recognise that there are different categories of research conducted in the medical and health sciences. These different categories need to be considered separately as their different characteristics are likely to have implications for how they should be costed or supported. For instance some of these categories of research may be better supported through funding of the hospital sector than others which may already have more appropriate funding instruments for their support. The RACP recommends a typology based on the following research foci:

- **Clinical Research** This is research conducted with human subjects (or on material of human origin such as tissues, specimens and cognitive phenomena) for which an investigator (or colleague) directly interacts with human subjects.
- **Health Services and Health Systems Research** Physicians have a clear role in this area of research which is arguably the most hospital based. This is an area of growing importance, as increasing pressures on the health system means that the health sector must become more adept at driving innovation and change more quickly in a safe and cost effective manner.

A significant problem with the proposed costing study is its omission of the costs of research activities that may be undertaken in conjunction with patient care (i.e. embedded research costs). This omission contradicts the McKeon Review's finding that

'The aim of embedding research in healthcare delivery is to facilitate overt involvement of the health-delivery workforce in research, with the result that it would be a routine and universally accepted component of healthcare. Research would be carried out across every facet of healthcare delivery, not necessarily by each and every healthcare practitioner, but by all categories of healthcare practitioners.'

It is also problematic in light of the categories of research above. One whole category of research, namely health services and health systems research significantly revolves around clinical service delivery particularly in the study of alternative models of care and clinical redesign. However, the omission of embedded research costs would have implications for more 'traditional' forms of research as well such as clinical research, as it ignores the contribution made by hospitals in running clinical research trials which require the expertise of medical and nursing staff.

Other complexities which are ignored in the discussion of research costs in the consultation paper are:

- Whether time spent by staff in writing grant applications would be included in estimating research costs even if these applications are ultimately unsuccessful. There is a significant opportunity cost to this time given the low NHMRC success rates. For instance a recent study found that preparing a new proposal took an average of 38 working days of researcher time and a resubmitted proposal took 28 working days, with an overall average of 34 days per proposal³ while a full ethics application to trial a new intervention can take a minimum of 12 hours preparation.⁴
- How the methodology would take account of the interface at a hospital level between industry, institute and university funded research. Costs would be expected to be quite variable from site to site due to the different local arrangements as to who bears the costs and how the clinical research involving hospital patients is conducted.

Conclusion

The RACP believes that it is vital that IHPA's proposed costing study on TTR in hospitals is undertaken appropriately, reflecting the importance of the subject matter. TTR in hospitals has significant public benefits in the form of delivering a highly-trained workforce and a healthcare system that is able to research and adopt improvements in healthcare interventions and models of care. The pressures on those who deliver TTR within hospital are increasing as medical specialist training becomes more formalised, robust and accountable. This in turn requires a greater time commitment from the supervisors, mentors, education heads and lead researchers; at times conflicting with the need for them to see more patients and deliver more health services. Thus we make the following recommendations:

1. Full details of the TTR activities which IHPA plans to measure and the data sources used must be provided to allow for proper consideration and effective feedback by stakeholders.
2. The qualitative methods that will be applied in proposed site consultations must be specified.
3. Site consultations must be sufficient to ensure an accurate representation that captures and reflects the diversity of organisations delivering TTR across Australia and the diversity of their locations and contexts, including rurality and population health needs.
4. Consultations must include academic clinicians with long-standing and recognised experience in teaching and/or research.

³ Herbert et al, 2013, 'On the time spent preparing grant proposals: an observational study of Australian researchers', *BMJ Open* 2013;3:e002800 doi:10.1136/bmjopen-2013-002800. Available at <http://bmjopen.bmj.com/content/3/5/e002800.full>

⁴ Input from consulted Fellow.

5. The following considerations must apply when determining an effective approach to costing embedded teaching and training (T&T):
 - a. Use of representative data and the appropriate evidence base, ensuring the ability to account for variation between sites and specialties, and employing a time and motion study coupled with focus group and interview data.
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