**South Metropolitan Health Service**

Medical Accreditation and Education Response to IHPA TTR Costing Study Public Consultation Paper December 2014

**Date: 29 January 2015**



South Metropolitan Health Service Medical Education and Training, Accreditation and Recruitment Committee (METARC) welcomes the opportunity to provide feedback to the Independent Hospital Pricing Authority (IHPA) on the Consultation Paper for the Pricing Framework for Australian Public Hospital Services 2015-16.

List of consultation questions as per consultation paper with responses following:

1. **Is it reasonable to use a ‘mixed’ costing approach, whereby:**

* **Direct and embedded T&T are costed using a bottom-up approach; and**
* **Indirect T&T and overheads are costed using a top-down approach?**

Yes – although a bottom up approach provides the ability to most accurately identify the cost of specific resources allocated to delivery of a training service.

The risks of utilising a ‘top down’ approach to collect data on indirect T&T are:

1. the reliance on accuracy of statistics and business intelligence to determine costs which may not always reflect real costs
2. variability between sites related to the resource framework in place to deliver training programs
3. apportioning costs across activities using statistics may not accurately reflect the fixed costs attached to delivery of an education program
4. **Are there any specific T&T activities (refer to step 1 of the T&T costing methodology) that should be captured as part of the costing study?**

**Direct**

* Lectures
* Direct Supervision
* Indirect supervision costs attached to administrative processes required to achieve prevocational and vocational requirements e.g.
* Development of training programs/learning objectives etc.
* Undertaking assessments
* Simulation training
* Delivery of orientation and induction programs
* Mandatory education modules (determined to deliver safe patient care)
* Interface with undergraduate medical education programs and clinical supervision of medical students
* Remediation of doctors/trainees within the service with identified deficiencies in clinical skills

**Indirect**

* Cost of operating education departments (medical, nursing, allied health) based on organisational structure and prevocational and vocational minimum staffing requirements – no current formulae to determine minimum requirements
* Time/costs involved in interface with medical school clinical placements
* Costs of delivering a Library and Information Service to support teaching, training and research activity

**Embedded**

Measurable attendances:

* Clinic sessions
* Minimum attendance/involvement in clinical procedures
* Sessional time involved in unit specific teaching/training
* Formal teaching sessions (tutorials, work groups, Morbidity & mortality reviews)

1. **How important will it be to capture embedded T&T that occurs in conjunction with patient care?**

Clinic attendance and procedure attendance are measurable and can be captured.

Attendance in ward rounds is more resource intensive to measure and probably unreliable. This combined with the fact that a primary function of ward rounds relates to service delivery and patient safety as opposed to teaching and training may determine it impractical to include in T&T. However a “proportion of costs” should be considered, as invaluable teaching and training occurs at these times.

1. **Do you think that embedded T&T can be aligned to the amount of other (direct and indirect) T&T taking place in hospitals?**

Yes – Measurable attendances:

* Clinic sessions
* Minimum attendance/involvement in clinical procedures
* Formal teaching sessions (tutorials, work groups, Morbidity & mortality reviews)

1. **Is it practical or feasible to capture embedded T&T?**

Yes – as a proportion of participation as per answer to point 4

Whilst it is acknowledged that this would at best be an estimation to capture   
 teaching and training as an embedded T&T, to exclude it would not accurately   
 represent the scope of T&T.

An appropriate formula would need to be determined to capture embedded T&T.

1. **If so, should the study aim to capture costs associated with**

* trainees and trainers not actively participating in patient care;
* Yes – to exclude this information would not provide a complete cost to delivery of a T&T program
* Cost of delivering mentoring and experiential training experience
* Mapping undergraduate teaching activity in the health service
* reduced productivity; and/or
* Is it feasible to collect information against these criteria, and is there a moral query regarding the minimum standard or measurability of reduced productivity in the training environment
* Consumable use increase.
* As per above point of reduced productivity and lost efficiency in costing against individual trainees
* There should also be an attempt to capture the required infrastructural costs which support the programmes e.g. secretarial time and hardware costs such as audio-visual production costs, booking process time etc.

1. **How might embedded T&T be captured in a way that is robust, delineates T&T from patient care and also minimises impost on clinicians, trainees and health services?**

* Clinic attendance costs: data source from rosters
* Procedure: DRG costing by clinician per session (trainee rostered to sessions). Note: This may not accurately reflect trainee attendance
* Formal teaching sessions (tutorials, work groups, Morbidity & mortality reviews)

1. **Are there any other important considerations that should be taken into account when deciding whether embedded T&T should be in-scope for data collection?**

* Organisational methodology to collect data
* Costs attached to data collection including:
* Fixed costs of human resources
* Costs and program variability of electronic data collection processes
* Hardware costs for data management instrumentation

1. **Are there any specific research products (refer to step 1 of the research costing methodology) that should be captured as part of this costing study?**

* Total fixed administrative costs attached to:
* Administrative costs in servicing a Human Research and Ethics Committee (HREC) and its functions
* Administrative costs in servicing Site Specific Assessments to a HREC
* Managing grants processes
* Coordination and delivery of clinical trials
* Can be measured by FTE costs allocated to above products and services.

1. **Is there any data that should be collected, which does not appear in Appendix B?**

Medical work profile could include service registrars not enrolled in a specialty training programs.

1. **Are there any data items listed in Appendix B that you believe are unnecessary?**

No

1. **What systems exist (for example, within health services, jurisdictional health departments or peak bodies) that can provide the data items in Appendix B?**

* Site based performance and activity units
* Area wide Business Intelligence Unit (or how so ever named)
* Whole of state health system Performance Activity and Quality reporting systems

These observations reflect the opinions of stakeholders working in medical   
 accreditation and training portfolios and do not represent financial opinion or expertise   
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