CHILDREN'S HEALTHCARE AUSTRALASIA

WOMEN'S HEALTHCARE AUSTRALASIA

TTR Consultation Team
Independent Hospital Pricing Authority
Via email: submissions.ihpa@ihpa.gov.au

WCHA response to Teaching Training & Research Costing Study Consultation Paper.

Thank you for the opportunity to provide comment in response to the Teaching Training & Research Costing Study Consultation Paper.

Children's Healthcare Australasia (CHA) is the peak body for hospitals providing paediatric health care across Australia and New Zealand, while its sister organisation, Women's Healthcare Australasia (WHA) is the peak body for hospitals providing maternity and women's health services across Australia. Together, these organisations represent more than 100 hospitals in these 2 sectors of healthcare, including the majority of women's and children's services engaged in teaching and training of health workforce in these sectors, and the majority of the research effort involving acute clinical care of women and children.

December through January is a challenging time of year to secure feedback from our members as we find key individuals are either taking well earned leave or covering for colleagues who are doing so. However we have consulted with many of our members who stand to be most affected by the final TTR classification for their comment and offer the enclosed responses to the consultation questions.

In general, both WHA and CHA members welcomed the approach proposed in the consultation paper. The paper itself is clearly and succinctly set out which was appreciated. Members felt that the proposed methodology for the study looks "pretty reasonable". They supported T&T costs being broken down into direct, indirect and embedded, though some members are concerned about how embedded costs will be measured. Members indicated they believe the focus on research capability is a sensible basis for comparison between services, disciplines and jurisdictions.

The issue for most members (as is acknowledged in the discussion paper) will be data collection, as some of the data items proposed to be collected are not currently automated in most hospitals. Having said that, a number of members related that they did not see the data items proposed to be collected in Appendix B as being as onerous as patient level data collections. There was a sense of optimism that this dataset can become collectable if required.

Specific comments provided in response to the consultation questions are provided overleaf.

Yours sincerely,

Dr Barbara Vernon
Chief Executive Officer
30 January 2015

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?**

    WCHA members support the proposed use of a mixed costing approach and the rationale for this outlined on pages 15 and 16 of the discussion paper. Members agreed that a 'bottom' up approach would better capture variation in teaching and training between health services but cautioned that there may be issues obtaining accurate data to support the bottom up approach. One member also proposed that the direct and embedded cost must include research costs.

2. **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?**

    Members offered the following comments in relation to this question:
    - Our members noted the need to capture both face-to-face modalities and on-line activities as well as the preparation time for both sets of activities.
    - The direct and intensive supervision that is required for midwives/medical students and JMO's in Birth Suite particularly needs to be captured in some way.
    - T&T costs provided outside an individual health service, e.g. statewide education programmes in which our staff participate, also need to be considered

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

    This is extremely important in the view of many of our members. They are concerned that if this is not appropriately captured the bed side learning that is so vital in health care will be threatened and it is often the most valuable learning that occurs. They propose that in designing a T&T classification, we need to make an assumption that clinical service delivery by its nature includes T&T albeit while recognizing that it cannot be adequately quantified. T&T in conjunction with patient care is also a very important component in understanding productivity.

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

    WCHA received very different opinions in response to this question. Some members answered "Yes", other, "Possibly" and some "no".

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

    Again there are mixed opinions on this question with no clear consensus view. Some health services responded that "it would not be practical or feasible to measure and capture T&T embedded in patient care". Some even cautioned that to try to introduce metrics may introduce perverse incentives that risk disrupting effective clinical education and development of students and junior staff.

Others take a more optimistic views:

- Although this area is likely to be difficult to measure, it should be feasible to come up with some measures that can be consistently applied across services and disciplines".
- Probably feasible but data collection may be problematic and may require the development of 'allocation' metrics
- Yes…in direct supervised hours required. In areas such as theatre, ED, antenatal clinics and birthing units this is both possible and necessary.

6. **If so, should the study aim to capture costs associated with**
    - **trainees and trainers not actively participating in patient care;**

      Yes - include those not involved with care.
    - **reduced productivity; and/or**

      Yes - capture costs associated with productivity. Term "productivity' very narrow definition as teaching/training is an integral part of all heath care workers output.
    - **consumable use increase.**

      No - Consumables probably irrelevant and would be an insignificant part of costs.
7. **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?**

   Again our members offer some differing opinions on this question:

   - Specific definitions and examples around what is counted under each activity delineating from direct patient care would be of significant importance. For example, teaching and training through the "Ward Round" activity could be interpreted differently across medical, nursing and allied health depending on their role in the context of a ward round. Examples would need to be explicit for each group.
   - Each professional group should be able to quantify what is required in terms of direct supervision. For example Midwifery Students must always have direct supervision in Birth Suite and this can be quantified based on their requirements.
   - To try and quantify embedded T&T on a regular ongoing basis would be very difficult and involve tedious documentation from trainers and trainees. Some simpler allocation based on the number of trainees and evidence of systems in place to ensure T&T delivery is needed. The same issue applies to other costs. To embark on a complex system with coded activity and the need to document and report every item will be far from ideal. A system of weighting applied to ABF costs that is based on demonstration of systems in place and operating effectively would be much preferable.

8. 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?

This is a means of quantifying the work that is done in developing the next generation of health professionals thereby ensuring continuation of this support. However, consideration needs to be given to the ability to collect accurate data that is consistent across all hospitals and that is consistent *within* hospitals across different disciplines and streams. There may be more value in comparing data by discipline across hospitals (ie. Allied Health, Medical, Nursing, Operational staff).

9. 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?

WCHA members offer the following suggestions:

- Approvals processes outside of HREC processes.
- Recruitment processes utilising hospital staff.
- Staff time in co-ordinating and supporting staff involved in research is valuable and should be quantified.
- Governance & Ethics, Leadership & Strategy, Support& Infrastructure and Facilities Management related to research.

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

Some members responded that the range of metrics in Appendix B look comprehensive and relevant. Others offer the following additional data items for consideration:

- Other Professionals (e.g. Health Information Management, accounting), Facilities Management (Maintenance)
- B4 Research 'administration" needs to explicitly include research nurses, data managers and admin support
- B5 number of participants requires some denominator to be meaningful.
- Translational impact should be included

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

No.

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

WCHA members identified the following standard data systems:

- Hospital and university information systems.
- Local decision support systems, payroll, general ledger
- Local databases Research, training and education

Thank you for the opportunity to provide comment on the proposed approach to this costing study. A number of our members have indicated they are participating in the study and will be happy to provide more detailed information to the study team throughout the testing phase.

For further information please contact:

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