



ACRRM SUBMISSION

To the Independent Hospital Pricing Authority in response to its Public Consultation Paper into development of a Teaching, Training and Research Costing Study January 2015

GENERAL COMMENTS

In developing a Teaching, Training and Research (TTR) Costing framework, the College would like to emphasise the importance of recognising that best practice medical service delivery in the rural and remote community paradigm involves distinctive training models. Rural and remote communities are defined by their geographic distance from a full complement of medical and other health services, resources and specialist staff. They are often also characterised by particular demographic and socio-economic patterns with corresponding patterns of medical care needs. These special circumstances need to be integrated into the costing framework.

Key points of distinction to be incorporated into the models are listed below:

- **Rural doctor training incorporates movement across a range of training settings including between the (state-funded) hospital sector and the (federally-funded), private practice and public health sector.**
To build a workforce which can meet the distinctive requirements of rural medical service provision, ACRRM Fellows are trained to be able to provide primary care as well as procedural, emergency and other advanced services in hospital settings, general practice clinics, and community-based services. Fellows and trainees both commonly work in roles which combine these skills in accordance with the needs of their local setting. (For example: as general practitioners providing additional procedural services as hospital visiting medical officers; working in Aboriginal Medical Services, or for organisations such as the Royal Flying Doctor Service).
- **Rural medical workforce training needs to be predominantly located and organisationally-based in rural areas and led by doctors with rural-training and rural perspectives.**
Workforce development and retention is a critical component of training program design for rural practitioner TTR. There is now an overwhelming body of evidence to support the importance of training centred on rural locations in producing practitioners who are likely to become permanent rural practitioners. Furthermore the special rural practice skill set is best taught by its practitioners.
- **Distinct models of training and medical care are essential to quality medical training and services in rural and remote locations including new and emerging models.**
The geographic distance from a full suite of support staff and resources necessitates location-specific models of care based on available resources and the practicalities of patient transport. These increasingly include interaction between remote (usually metropolitan hospital based) specialists working with local rural and remote medical practitioners and trainees. These may be delivered through electronic communications or through visiting specialist models. They have cost implications for both the urban

hospital and the rural hospital/clinic including technological and/or transport costs to be assigned appropriately between the two employer organisations.

- **Rurally-based training is delivered on a much smaller scale, creating fundamentally different economic structures to their urban hospital counterparts. Minor changes to financing or teaching time, will disproportionately affect both the service's viability and the provision of services for that community.** Fixed training costs are largely the same irrespective of location however rural hospitals have smaller cohorts and a much smaller pool of staff and resources to draw upon, making the financial impost upon the rural hospital greater. Secondly, as rural hospitals are constrained to the small pool of practitioners available in the locality, the rural trainer and the rural community doctor are typically one and the same, and time devoted to training is time taken from essential service delivery.

RESPONSES TO QUESTIONS

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?***

The approach of identifying costs according to activities rather than number of trainees is supported as this overcomes the problem of trainees being taught by staff of a range of different hospitals and moving between hospitals in order to meet their educational requirements.

As above it will be important to give consideration to the complexities of models of training which involve collaborative training between doctors and trainees employed by different hospitals and other practice sites. For example in Queensland, telehealth consultations with urban-based specialists are an important learning tool for general practice registrars in rural locations, facilitating education and upskilling and broadening their scope of practice. These need to be funded at both ends of the consultations, by both Queensland Health, and through the Medical Benefits Scheme.

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?***

As above it is important to include in this list teaching sessions which are provided through electronic means or which involve transport costs of visiting teachers to the teaching location which may be remote from their regular workplace.

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

The complexities and challenges associated with measuring the costs of embedded T&T are acknowledged. The College nonetheless, considers it necessary to endeavour to undertake this. The diversity of models of care that the study incorporates, make it implausible that any generalisation with regard to the alignment of embedded T&T and other forms of T&T will be reflective in all instances.

The College would especially emphasise the importance of including direct, indirect and embedded costs in the funding models for smaller health facilities in rural areas. These facilities do not have the benefit of economies of scale in terms of staff and resources allocation and small funding anomalies can be prohibitive. As the local pool of medical trainers is small, the mix of direct, indirect and embedded T&T taking place in the rural hospital may be heavily influenced by the local health service demands on those same rural doctors and this should not adversely affect the overall quantum that they receive.

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

All the above options are broadly supported however a combination of measures is necessary in order to avoid creating adverse incentives. For example, the first option in isolation could potentially create a disincentive to hospitals to engage in embedded T&T. In the rural hospital context this is often governed by the exigencies of local service demands on the rural doctors who are potentially providing the training and hence a poor representation of the actual training taking place.

- 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?***

Medical specialists (who are now located almost entirely in metropolitan or major regional hospitals) should ideally have a measure of their training contribution explicitly referenced in their employment arrangements and this should include provision of training in hospitals other than their employer hospital.

It is noted that embedded training demands vary in scale and scope across specialties and this would be a useful reference point. This ideally would be considered together with some measure of demands associated with the specific work location.

- 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?***

As above it is important to incorporate consideration of embedded T&T through the use of electronic communications and also through visiting consultant models.

- 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?***

No specific comments to add.

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

No specific comments to add.

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

No specific comments to add.

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

No specific comments to add.