Medical Deans
AUSTRALIA AND NEW ZEALAND

Activity Based Funding for Australian Public Hospitals: Towards a Pricing Framework

Submission from
Medical Deans Australia & New Zealand Inc

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1. A Pricing Framework for Teaching, Training & Research: The Key Points of Our Submission

Below are the key general points that Medical Deans Australia and New Zealand Inc ('Medical Deans') wish to make in this submission. The Appendix to this submission presents our response to particular consultation questions.

1.1 Guiding principles

We urge the Independent Hospital Pricing Authority (IHPA) to include in its set of guiding principles one relating to medical teaching, training and research (TTR), to reflect the fundamental importance of a well trained workforce and research to delivery of an effective health service. That principle could be worded, for example, as:

> *"ABF should support the maintenance of a highly qualified and well-trained medical workforce through the provision of clinical training and maintenance of research in public hospitals".*

Such a principle would reassure professional bodies (as well as educators) that the focus on activity based funding (ABF) and an efficient price (EP) for health services, and achievement of service performance targets, will not be at the expense of workforce development or medical research.

1.2 Rationalising funding arrangements

Medical Deans considers there would be high value in examining how to rationalise and streamline the current patchwork of funding arrangements that underpin medical education, in order to improve transparency, and understand its real costs, outputs and benefits. This work would have two key domains:

1) IHPA's work is taking place at the same time as the Commonwealth Government's response to the Higher Education Base Funding Review's recommendations. There is a unique opportunity to align the two areas of work to strengthen TTR in public hospitals. In determining its approach to TTR, the Deans urge the IHPA to recognise the interdependence of the changes flowing from the introduction of ABF and the implementation of the Base Funding Review. Medical Deans also emphasizes that unbundling and moving to either block or activity based payment (or a combination of both) for hospital-based TTR will not in itself address issues of underfunding and cross-subsidisation - within the hospital or the university.

2) Similarly, Medical Deans is concerned that the IHPA's work will not address a critical issue facing the health sector – how to align education and training to future workforce requirements, such as new models of care, new workforce roles, and team-based practice. The issue is the domain of Health Workforce Australia (HWA), and Medical Deans suggests that IHPA should carefully consider how its decisions on TTR funding might provide an opportunity for clarification of HWA's intended future role in the system in respect of medical education and clinical training. The original policy intention appears to have been for HWA to become a national planner and funder of health professional education and training. However this did not eventuate, and its current responsibilities are limited to partial funding of new professional entry (undergraduate/graduate entry) student places without any role in funding the much larger 'core' of professional entry places or postgraduate (prevocational and vocational) training places. Work on development of a new funding approach to hospital-based TTR creates an environment in which the intended flow of funding for TTR in hospitals – and the role of HWA in this, if any - should be clarified, as should the current and intended application of HWA's innovation funds.

1.3 Timeline for addressing TTR

The COAG agreement sets 2018 as a deadline by which time a long term funding approach to TTR funding must be recommended by IHPA. This lead-time is intended to allow a considered and deliberate approach

to the challenging task of unbundling TTR from health services, applying an EP, and determining the funding methodology.

However, Medical Deans believes that the length of this lead-time risks TTR becoming a second-order priority. We consider that work on TTR should not be delayed, both because of its complexity, and because of the potentially serious 'unintended consequences' for TTR that may arise from movement to ABF and EP for health services without understanding the impact on TTR. Medical Deans does not regard 2018 as an appropriate target date for resolution of TTR funding; we believe the course needs to have been determined and implementation well underway by that time.

1.4 Getting the start point right

For Medical Deans it is critical that the 1 July 2012 start point is accurate and is determined in a transparent manner, both to demonstrate the widely diverse and inconsistent funding arrangements that currently exist, and to establish a baseline level of funding to avoid erosion while longer term TTR arrangements are being determined.

We propose establishment of a joint working group at the earliest opportunity, to provide advice on setting the baseline and to undertake medium to longer term work programs (see section 1.7 below).

1.5 Moving beyond block funding

Medical Deans is also concerned that the adoption of block funding as the initial approach for TTR may be irreversible. We advocate relatively early adoption of some form of ABF for TTR, possibly in combination with block funding to recognise the level of fixed costs of TTR infrastructure in hospitals. We consider that this should be a specific ABF and EP for TTR, rather than being a 'sub-component' of the ABF and EP for health services. Targeted ABF for TTR would allow funding to follow the student, which is an important principle within the tertiary education sector and one that would mean hospitals would be incentivised to pursue training opportunities – which is essential given the increasing numbers of medical students and recent graduates requiring clinical placements. We further suggest that the ABF and EP should recognise the core research role of senior clinical teachers and fellows in hospitals, and deliver a 'base' level of funding support on which specific research grants can build. Again the existence of such a funding stream would incentivise hospital administrators to value clinical research and application of its findings, and consider these as core functions of a health service.

1.6 Measuring performance

Medical Deans strongly supports the introduction of explicit accountability for TTR in public hospitals, to complement the dedicated funding stream. We are committed to working with the National Health Performance Authority to develop a suite of key performance indicators for high quality medical TTR, and ensure transparency through reporting against these indicators.

1.7 A partnership approach

Given the importance and complexity of these matters, Medical Deans considers it imperative that we work in partnership with IHPA (and other parties as appropriate) to design and implement the best approach. We propose the urgent establishment of a national joint work group, with Medical Deans' membership and with three objectives:

1) Provide advice to COAG on setting of the 2012/13 baseline
2) Provide advice to IHPA on the approach that should be used in 2013/14 when it assumes responsibility for determining the level of block funding
3) Provide advice to IHPA on a preferred long term funding approach, a transition path, and an associated work program.

Medical Deans considers that the work group should be given a delivery target for objective 2 of 31 December 2012, and for objective 3 of 30 June 2013.

1.8 Maintaining stability

Current arrangements for funding and delivery of TTR are many and varied across Australia. It will be critical that the formal and informal relationships between medical schools and hospitals are not disrupted or destabilised until IHPA has completed its work on longer term pricing, and any other required policy or institutional arrangements are confirmed. Maintenance of the status quo and managed transition to new arrangements should be included in the brief for the joint work group described above.

1.9 Learning from international experience

In developing our understanding of how ABF and EP might impact on TTR, Medical Deans has carefully considered the international experience in this domain. It is apparent that nations have devised a range of different models for addressing:

- How core medical school activities are funded – usually based on the number of students, with some sort of inflation adjustment to maintain the value of the funding. Student results can also be a factor in funding distribution.
- How hospitals are funded to support clinical education by providing facilities and staffing – through Education or Health Departments, or both. Teaching hospitals are usually compensated at a higher rate than non-teaching hospitals to reflect the higher costs associated with their teaching role
- How research associated with medical education is funded – if differentiated, usually through 'base funding' which is separate from research-funded through competitive grant applications.

There is general agreement that having undergraduate or postgraduate trainees within a health care service results in increased costs and some reduction in service delivery(net of benefits). Internationally, jurisdictions have dealt with this issue in two ways:

1. The so-called 'knock for knock' solution, whereby the system in its entirety recognises that organisations taking trainees are expected to incur higher costs and this is reflected within their core funding packages and expectations of output costs. Within such a system, it is recognised that benefits flow in both directions, that distinguishing and quantifying clinical training and health service costs is extremely difficult, and that the transactional costs of doing so would out-weigh any benefit.
2. The so-called 'unbundled' system, whereby the costs of teaching and training are disaggregated from those of health service delivery. In New Zealand, for example, from the mid-1990s, dedicated funding has been provided to medical schools to pay hospitals for a range of point-of-care teaching and learning opportunities for professional-entry level students, while a Clinical Training Agency (now Health Workforce New Zealand) has been established as the national funder of postgraduate (pre-vocational and vocational) clinical training.

Australia has elected to pursue the second path. International experience clearly shows that, to access the high quality clinical learning environments for students and maintenance of constructive medical school-health service relationships, are both critically dependent on the medical school (or another funder) making appropriate payments to the hospital to cover the costs incurred. What is difficult is quantifying the exact nature and magnitude of these costs, translating them into 'efficient costs', and adjusting funding at regular intervals to match unavoidable cost inflation.

Medical Deans proposes that IHPA gives priority to a thorough literature review of the international experience in 'unbundled' funding of TTR.

2. Background

2.1 Focus of this submission

Medical Deans welcomes the opportunity to make a submission to the IHPA in their development of a Pricing Framework to support ABF and EP for Australian public hospitals. Medical Deans is very strongly committed to the successful design, implementation and operation of this key aspect of the Australian Health Reforms.

Medical education is a broad domain, but the Medical Deans' submission on the proposed Pricing Framework is focused on:

- Medical education only, although many of the points raised are also relevant to other health professional groups.
- Undergraduate education, rather than postgraduate or continuing education (both of which will also need to be considered in IHPA's work).
- Teaching, training and research (TTR), which are the inter-linked core business of a medical school.
- The hospital-based dimensions of TTR (ie, those related to the placement of medical students in hospitals for the purposes of clinical training).
- The ABF and EP aspects of Health Reform, and how they will apply to TTR.

In this submission we make a number of general observations regarding the context in which IHPA is developing the Pricing Framework for TTR, and then respond to the specific consultation questions are they relate to TTR.

TTR activities are and will continue to be a critical component of the Australian health system. They have been shown to increase the quality of health services, and are obviously fundamental to delivering the health workforce of the future. When health services are under pressure – as they will be for at least the medium term horizon – TTR investment and activities are placed at risk. Hence it is important that there is a separate funding stream for such services that supports productive health care delivery, and creates incentives for hospitals to attract students and undertake research. A strong partnership must be developed and maintained between the teaching hospital and the university, in both clinical services and related research, as well as in education.

However, introducing this separate funding model will be challenging. It is not widely understood that ABF and EP will be applied to TTR separately from its application to health service delivery, and that doing this will require a complex technical exercise of 'unbundling' of inputs and outputs, and then pricing across all Australian public hospitals and medical schools. Nor is it widely understood that this will be more than a technical exercise; experience elsewhere indicates that the undertaking will raise significant concerns amongst senior clinicians, and trigger difficult debates about medical education, and the boundary between clinical practice and clinical teaching.

For these reasons, Medical Deans has been following developments to date in this domain very closely, and wish to work in partnership with IHPA to ensure that the ABF and EP arrangements for TTR do indeed add value to medical education and hospital services.

2.2 The medical education context

As Medical Deans pointed to in its submission to the Higher Education Base Funding Review[1], dramatic changes have occurred in recent decades in Australian medical education:

- The number of medical schools has grown from eight in the 1970s to 18 today.
- The number of commencing medical students has more than doubled between 2000 and 2010.
- There has been a three-fold growth in international medical graduates.

[1] *Submission to the Australian Government's Base Funding Review of Higher Education*. Medical Deans Australia and New Zealand. 31 March 2011

- New models of medical education have evolved, including graduate entry programs and the uptake of problem-based learning as the dominant paradigm.
- The Rural Clinical Schools program has expanded the locations and settings for delivery of medical education.

The Deans have a number of concerns about the nature of the funding model for medical schools, as well as the quantum of funding. Specific issues include:

- The above changes have impacted on the cost structure of medical education, and most have occurred since the development in the early 1990s of the model that established funding relativities under the Base Funding Grant.
- Government funding of Australian medical education remains very low compared with international benchmarks, and requires cross-subsidisation within the universities (and potentially within hospitals).
- Base Funding arrangements should reflect the vital importance of ensuring that teaching of medical students occurs in a research-active environment.
- Funding should not be directly linked to student participation or satisfaction measures, as there is evidence that such measures do not necessarily correlate with the acquisition of medical knowledge and competencies.

Of fundamental importance to medical education is maintenance of 'work-integrated learning', in public hospitals in particular. This clinical training is a cornerstone of Australian medical education but, as the Medical Deans stated in its submission to the Base Funding Review, this is now at risk:

- New Government funding through Health Workforce Australia only provides a partial contribution towards the costs of new clinical placements after 2009; it does not cover the costs associated with the doubling of medical student numbers since 2000.
- Pro bono medical teaching is being eroded due to demographic, cultural and funding pressures; it represents a potentially significant hidden cost that is yet to be included in the cost structure or funding model of higher education.

The Rural Clinical Schools program provides a good example of the high quality outcomes that can be achieved with sufficient investment in medical education. This will need ongoing investment to sustain clinical education in rural Australia.

Consideration of the future funding and pricing of TTR in hospitals raises a number of questions:

- How will TTR be defined, and what dimensions of it will be funded through ABF?
- What quantum of funding will be available?
- Through what agencies will the funding be channeled?
- Through what pricing and funding mechanisms will the resources be made available?
- What volume, content or quality specifications will accompany funding, and what accountability reporting will be required?

Whilst some of these are outside the direct scope of the IHPA's work, they are all questions that will arise in the course of development of the Pricing Framework for TTR as IHPA shifts the implicit to explicit.

To date, hospital-related TTR funds have been from multiple sources:

- The bundled hospitals payment from Commonwealth to states, and that is implicitly included in the payment from states to hospitals. The Commonwealth TTR funding quantum is clear, but its use is neither specified nor monitored.
- Supplementary payments from states.
- Supplementary payments from Health Workforce Australia.
- Payments from medical schools.
- Supplementary research grants.

2.3 The Higher Education Base Funding Review

IHPA has begun its work concurrent with release of the findings of the Higher Education Base Funding Review that recommended a set of principles to guide long-term funding for universities, plus a reformed funding model.

The Review Report[2] released in December 2011 contains recommendations that are highly relevant to considering the place of TTR in an ABF environment. The recommended principles of greatest relevance to this are:

- Base Funding should support innovative teaching and 'base research capability'.
- The Base Funding model should be simple and transparent, and reflect the relative costs for different disciplines or modes of teaching.
- The model should allow institutions to allocate resources internally to fit their priorities, and institutions should be accountable for that allocation.
- Targeted policy objectives should be supported by supplementary funding.

Table 1 below identifies the Base Funding Review's recommendations of greatest relevance to medical education and clinical training, and their implications.

Medical Deans understands that the Commonwealth Government intends to consult on the Base Funding Review report during February and March 2012 to inform its response, which is expected in mid-2012. Decisions relating to Base Funding will have a significant impact on medical education, and it will be critical that these are congruent with those relating to Health Reform – including ABF and EP for TTR.

[2] *Higher Education Base Funding Review: Final Report*. Expert Panel, October 2011

Table 1. Implications for medical education of selected recommendations of the Base Funding Review

Recommendation	**Implication**
An increase in the level of Base Funding per student, plus an additional increase to support appropriate teaching facilities and technologies	Increased government revenue for universities generally, with the targeted facilities and technology increment likely to benefit medical education
Indicators of quality and resourcing should be developed to allow regular reporting and international benchmarking	Opportunity to align this with Health Reform in respect of the role of the IHPA, and the National Health Performance Authority
A standardised cost measurement system should be introduced (including the internal and external costs of work-integrated learning)	This will be an important reinforcement of the unbundling associated with ABF and EP, and together will mean standardised costing of the entirety of medical school activity. Coordination of the two streams will be important
Medicine is one of a number of underfunded disciplines	Medical education will be targeted for increased funding, reducing the need for cross-subsidisation with the university. The overall increase in university funding should mean that the increase for medicine is not at the expense of other faculties
The number of funding clusters should be reduced, and relativities amended to better reflect costs	Overall simplification of the funding model, and funding better matching costs
Performance incentives should be separately funded to promote quality teaching	Teaching quality will be rewarded in the funding model, with the ability of medical schools to earn additional revenue on top of the Base
Measures should be introduced relating to student retention and completion	The funding model will have measures and incentives for retention and completion
'Flagship programs' should be funded at a higher rate, and regularly evaluated	Creates the opportunity for individual schools to position medicine in the 'flagship' category
Base research capability could be funded based on student load, or on research outputs	Together with the principle that Base Funding should support innovative teaching and 'base research capability', this suggests that base research may be costed and funded separately from teaching and training
The costs of medical (and other Health and Education) placements should be assessed, and the roles of the various jurisdictional governments and employers defined	Reinforces the ABF-related action to cost medical placements, and raises the issue of organisational responsibility for funding

3. The Pricing Framework

Medical Deans has followed closely the emerging thinking of IHPA on ABF, as reflected in the three publicly released documents.

We consider that the **ABF Literature Review**[3] provides a highly relevant context for considering pricing and funding of TTR, even though its focus is on health services. Medical Deans supports the lessons and implications presented in the conclusion of the Literature Review and consider them applicable to TTR, and in particular that:

- 'Efficiency' should be both technical and allocative, relating to 'the right price for the right product'. The EP should support cost-effective innovation and high quality care.
- Definition of efficient performance should be grounded in practical realities rather than economic theory, and movement to an EP should be empirical and incremental.
- ABF implementation internationally is generally phased in to minimise financial risks to hospitals, and most systems maintain some blend of ABF plus block funding. A transitional pathway will be applied from July 2012 and emphasise transparency and stability.
- The pricing approach should be grounded in policy decisions on what payment reform is intended to achieve in the short and long term. The aim of introducing payment reform is to improve quality, access and care coordination through innovation and learning.
- The pricing approach is closely linked to the scope of services that will be funded via ABF, which in turn is dependent on having common output measures.
- In Australia ABF will operate within a capped budget environment (as opposed to open-ended payment per case). This will have significant impacts on pricing design.
- Price setting will need to balance national consistency of EP with adjustments to compensate for unavoidable cost variation.

The **Summary Report on the Pricing Framework**[4] considers ABF and the EP generally, and specific references to hospital-based TTR are few. The Medical Deans are concerned that the very limited discussion of TTR in the Summary Report may suggest a lack of recognition of the key role of TTR in public hospitals, and the risks and opportunities created by movement to ABF and an EP.

However, Medical Deans is pleased to see that the full **consultation document on the Pricing Framework**[5] contains a more comprehensive coverage of matters directly relevant to TTR, and also of general points relating to ABF and EP that are likely to be applied to TTR.

We have presented the key general points of our submission on the consultation document in Section 1. The Appendix to this submission presents our response to particular consultation questions.

[3] *Literature Review: Efficiency, international best practice in ABF and future payment reform*. Health Policy Solutions, November 2011
[4] *Towards a Pricing Framework: Summary Report*. Health Policy Solutions. December 2011
[5] *Activity based funding for Australian public hospitals: Towards a Pricing Framework*. Health Policy Solutions. December 2011

4. Conclusions

COAG has determined that as part of the Health Reform agenda, hospital-based TTR will move to an EP, and potentially an ABF model will replace the block funding mechanism (or complement it). Medical Deans supports this decision, and consider that it should be given greater emphasis in the Pricing Framework by adding an additional Principle (see Section 1 of this submission), and by giving greater priority to TTR in developing and implementing the ABF pricing and funding approach.

Our submission also makes other key points in respect of:

- Rationalising funding arrangements.
- The timeline for addressing TTR.
- Getting the start point right.
- Moving on from block funding.
- Measuring performance.
- A partnership approach.
- Learning from international experience

as well as responding in greater detail to the specific consultation questions asked by IHPA (see the Appendix).

Unbundling and pricing of TTR is technically very complex, will raise concern amongst senior clinicians, and will trigger difficult debates about medical education, and the boundary between clinical practice and clinical teaching. From a professional perspective, for many senior doctors teaching is core to the Hippocratic tradition and fundamental to medical practice. Learners may impinge service productivity, but many of the most productive and innovative senior doctors work in public hospitals because of the value they see in teaching and consider it to be an essential and attractive part of their job. The same is true for research. And from an organisational perspective, the medical profession as a whole can be expected to feel strongly that Local Hospital Networks and their hospitals must have a core accountability for development and recruitment of their future workforce.

For the Australian medical schools, the IHPA's work on ABF and EP comes in a watershed period, that offers the opportunity to address unresolved and inter-linked issues relating to the quantum and mechanisms of funding and pricing, and organisational responsibility. Together, decisions about Base Funding and ABF (and the role of HWA) are likely to have a fundamental impact on the resourcing and responsibility of medical schools and the environment in which they operate.

Medical Deans is committed to working closely and constructively with IHPA in designing and implementing a Pricing Framework that adds value to medical TTR, and to health service delivery.

Appendix: Responses to specific Pricing Framework consultation questions

Section number and topic	COAG decisions and IHPA proposals	Consultation questions	Response from Medical Deans
6. Setting the national efficient price	Efficiency is defined in both technical and allocative terms. A hospital operating at the national EP will: • Be able to provide the full scope of its services at or below the national benchmark • Implement new technologies which are cost-effective • Minimise harm to patients • Provide services that benefit the patient and population as much as services provided elsewhere in the system.	*6.1 Do you agree with the proposed definition for a hospital operating at the national efficient price?*	The proposal is consistent with the principles in the Literature Review, and seems appropriate and relevant. However the EP definition is focused on health services, and is not directly relevant to TTR – which is also to be efficiently priced. A broader definition encompassing TTR and workforce is required, or an additional definition specific to TTR.
	Price-setting requires specification of the product or service. There should be a single national unit of hospital service activity, to be called the National Weighted Activity Unit, to be designated by its year of operation (eg, NWAU 2012). This unit will apply across inpatient and outpatient activity.	*6.2.2 Is a single unified measure the right approach at this stage of development of ABF?*	The proposal is consistent with the principles proposed in the Literature Review, and seems appropriate and relevant. However, this measure applies to health services only, not TTR. No units are proposed for TTR; hence the proposal for block funding for a transitional period.
	Product definitions should be guided by what is best for patients, and minimise boundaries to avoid cost-shifting.	*6.2.3 Should the future design of ABF involve any non-traditional product definitions to minimise cost shifting externalities?* *If so, in what areas should they be considered?*	This appears a sensible definition. However, given the separate funders and pricing/ funding models for 'hospital' (IHPA/ABF) and 'primary care' (Commonwealth/Medicare item-of-service) health services, achievement of appropriate 'bundles of care' will be challenging. This also raises a question related to TTR: what would happen in a situation where a traditionally hospital-based service attracting TTR funding is shifted to a primary/ community based setting which has a different funding model for TTR? An annual review process may be required, given the likely continued evolution of care from hospital to community settings. Close co-ordination of national agencies will also be required to prevent development if 'siloed' funding.

Section number and topic	COAG decisions and IHPA proposals	Consultation questions	Response from Medical Deans
	There are three broad options for setting the EP level: • Best practice pricing, based on costing of evidence based care pathways • Average cost pricing (or alternatively median cost pricing) • Below-average cost pricing. Best practice pricing should be used in the future, with a transition pathway through 'central tendency' pricing and then below-average pricing. The start point would be 'observed costs'.	*6.3.4 Do you agree that it is too early in the development path of activity based funding in Australia to adopt best practice pricing as the standard approach?*	This is an important consideration for TTR as well as health services, although the link to TTR is not made in the document. The approach to EP would presumably apply under both block funding and ABF. The position proposed is pragmatic, but also consistent with the long term policy direction and principles. Best practice pricing would require definition of what constitutes best practice in TTR.
	Availability of robust cost data is critical. The best source is the National Hospital Costs Data Collection (NHCDC), to which two-thirds of public hospitals contribute. It shows wide variation in hospital costs. Costing has to date been focused on inpatient services. TTR costs have not been consistently captured, and hence some is likely to be currently recorded as health service costs – affecting efficiency measurement. Hence an aggressive approach to setting EP is inappropriate.	*6.3.4 Do you support a pricing strategy in the short-term based around the middle of the cost distribution? If so, should it be mean or median? What might be the indicators that could used to identify when a move away from such a strategy is appropriate?*	Again, the position proposed by the IHPA appears pragmatic, and consistent with the long term policy direction and principles. Availability of robust product definitions and cost data from a critical mass of hospitals would appear to be key indicators for progression. In respect of TTR, the journey will be slower because of the need to first establish the foundation of product definition.
	Moving to a price requires estimates of inflation as a basis for regular price review of both ABF and block services. The Australian Bureau of Statistics (ABS) produces an index of inflation that should be used for adjusting hospital costs. Consideration will be given to how to adjust for productivity improvement in 4-year projections	*6.3.5 Do you agree that the IHPA should use an output cost index to adjust cost data in setting the national efficient price?* *Are there other factors that should be considered in undertaking price indexation? What factors should be considered in developing 4-year projections of the national efficient price?*	An inflation adjuster is essential to ensure funding keeps its value. The ABS index appears well established in public hospitals, and hence may also be appropriate for TTR. Determining this will require understanding of the factors that are considered in the ABS index, and whether these adequately cover TTR related costs. Consideration of what constitutes productivity improvements in TTR will also be required.

Section number and topic	COAG decisions and IHPA proposals	Consultation questions	Response from Medical Deans
7. Adjusting the national efficient price	IHPA can adjust the EP for particular hospitals by using loadings where there are unavoidable cost variations relating to hospital size, type, location or patient characteristics. This needs to be balanced by ABF requiring the EP to be set independent of a particular hospital's actual costs. Only those factors cited in the Reform Agreement should be considered in the early Reform years, with patient characteristics being interpreted as relating to the indigenous population. Emphasis will be given to patient-related rather than provider-related factors to avoid cost differences created by providers.	*7.1 Do you agree that patient-related factors should always have pre-eminence?* *Do you agree with the proposed approach to dealing with loadings?*	This approach is consistent with the IHPA principles, however the principle of the Base Funding Review – that specific policy goals should receive dedicated funding - should also be considered. This would apply, for example, where a TTR function is required in a small hospital to support specific workforce policies. It may be that IHPA is seeing that block funding for small hospitals will address this; however, this factor is not mentioned in this section of the report. Other policy goals relating to TTR should also be considered.
		7.2.1 Do you think there is a case for a loading for the additional costs of treating Aboriginal and Torres Strait Islander people? *If so, what should be the evidence used for the loading?*	The IHPA premise is that casemix will compensate for patient complexity, but that indigenous populations have health needs that require resources additional to those for non-indigenous. This type of loading is often used in funding models internationally, and evidence supports the need for it.
		7.2.2 Do you think there is a case for a loading for the additional costs in specialist children's hospitals and units? *If so, what should be the evidence used for the loading?*	As the paper points out, the evidence here is less clear that there are costs above those that would be compensated for by casemix and adequate recompense for TTR. More analysis is needed.
	Evidence suggests there may be a case for loading 'remote' hospitals; however, this may be addressed by loading for indigenous populations. In addition, block funding of small rural hospitals provides an alternative approach.	*7.3 Do you think there is a case for a loading for the differences in costs for hospitals in different locations?* *If so, what should be the evidence used for the loading?*	More analysis is required. Note comments above (7.1) re funding of policy goals and use of block funding.
	Large teaching hospitals are more expensive because of: • patient complexity unrecognised in the casemix system; • teaching slowing down clinical practice; • diseconomies of scale; and • more complex patients within each DRG. Most hospitals provide some clinical education, some more than others.	*7.4 Do you think there is a case for a loading for the potential differences in costs for 'teaching hospitals'?* *If so, what should be the evidence used for the loading?*	There is strong international evidence to support this. The New Zealand experience following unbundling was that 'remoteness' was not the issue; rather the problem lay with the large tertiary/teaching hospitals that were found to be paying significantly higher salaries for senior clinicians in internationally scarce specialties. Whether this is a desirable and deliberate 'policy' that is supported in pricing needs to be determined by IHPA. Teaching hospital pricing is a highly technical domain that should be the subject of focused joint work.

Section number and topic	COAG decisions and IHPA proposals	Consultation questions	Response from Medical Deans
	There is currently no current way of sizing the TTR effort, hence the need to fund TTR by block grant rather than a loading on patient activity.	*How should 'teachingness' be defined?*	This question relates to metrics to measure 'teaching effort'. The costing process as part of unbundling will presumably identify direct input costs, and apportion a share of indirect costs. This will be sufficient for initial unbundling purposes. Subsequent movement to an EP will need to relate inputs to outputs. Internationally, funding models tend to use a mix of: • Student numbers, with a price related to each health professional group • A fixed price component, to reflect the non-variable nature of many costs. Therefore TTR may fit the IHPA criteria for a service to be funded by a mix of ABF and block (see below).
	Pay for quality and safety performance is a relatively new domain, and hence any implementation should be phased	*7.5.1 Do you think that some form of pay for performance incentives should be introduced with national implementation of ABF?*	Caution is warranted, as the risk of perverse incentives and unintended consequences is high. For such a regime to be introduced for TTR, a robust understanding of what constitutes the equivalent of quality and safety would be required, together with valid measures.
9. Block grant funding	ABF will be used wherever 'practicable'. Block funding levels will be via individual bilateral agreements for 2012/13, and unbundled block funding from 2013/14 as determined by IHPA. Block funding will be developed on the basis of 'efficient costs', adjusted annually. Block grants are to fund 'capacity' to deliver services. Block grants funded by the Commonwealth will cover 45% and then 50% as for ABF services. Little work has been done to date on block-funded services. Accountability structures for health services are clear (the LHNs); for services such as TTR this may need to exist at hospital level. States will have discretion as to the level of funding they allocate to block funded services, on top of the	*9.4.1 When is ABF 'impractical' to apply?*	This relates to the proposed 'technically impractical' criterion, and the Medical Deans concur with IHPA that this currently applies to TTR. We propose a joint work program to move promptly from impractical to feasible, and have suggested a timeline for this.

Section number and topic	COAG decisions and IHPA proposals	Consultation questions	Response from Medical Deans
	Commonwealth EP contribution. Consideration of whether TTR should move to ABF or other appropriate arrangements will be made no later than June 2018. Block funded services will have the type and level of activity and funding transparently reported.		
	Draft criteria for determining when services should be block funded are: • Technically impractical (ie, poor product specification; poor cost information; and/or no suitable units of output for counting and funding) • Absence of economies of scale (ie, the service has low volumes; instability or unpredictability of volumes; or a distorted mix). Funding over and above what would be earned through ABF (ie, a 'funding premium') is warranted in terms of a measurable policy objective.	*Are the proposed criteria for block grant funding suitable? Are there other factors (that are separate to the technical requirements and the economies of scale criteria) that may require consideration of the use of block grants?*	The two criteria appear appropriate. The second – economies of scale – may apply to TTR in a small hospital, where having locally based TTR is seen as essential for workforce availability reasons, eg to attract and retain local students, or to attract medical students to choose careers in rural settings. This would qualify as a measurable policy objective that should be considered for specific funding (as per the recommendation of the Base Funding Review).
		Should the criteria make transparent the 'funding premium' incorporated in block grants?	Transparency is proposed as a principle of the Pricing Framework, and it should be applied to any funding premium.
	The EP of block-funded services will be determined by reference to efficient costs, and will be reviewed annually to consider changes in service activity, scope, and cost. The states would determine the 'service expectations' that would accompany block funding, through service agreements with LHNs. Efficient cost methodologies would be developed, trialed and consulted on during 2012/13.	*9.4.2 What are your views on how to determine the efficient cost of block grant funded services?*	As discussed elsewhere, there are two broad options: (a) the costs of a theoretical 'model' hospital TTR service; or (b) comparison of costs of existing TTR services, and application of either median or below average pricing (with potential to move to best practice pricing in the longer term). The principles presented in the ABF Literature Review suggest that (b) will be pursued. As noted above, this will require application of common definitions of inputs and outputs, and the relationship between cost and volume. Best practice pricing will require identification of best practice in TTR.
	A mix of ABF and block funding may be suitable for some services, eg for large LHNs with teaching hospitals	*9.4.3 What factors might warrant the mixed use of ABF and block grant funding?* *Should specific criteria be developed that the IHPA can use to make determinations on a mixed approach to funding?*	As noted above (7.4), Internationally funding models for TTR tend to use a mix of: • Student numbers, with a price related to each health professional group • A fixed price component, to reflect the non-variable nature of many costs.

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			Therefore TTR may fit the IHPA criteria for a service to be funded by a mix of ABF and block. Factors to be considered are: • Is volume (ie, numbers of students) significantly variable and unpredictable in a hospital? This is unlikely to be the case • Does the numbers of student placements vary significantly by hospital? This is likely to be the case, meaning that cost per hospital will vary significantly because of the high fixed cost component. As the IHPA document states, until such time as ABF is used for TTR, then LHNs who have a teaching function in their hospital(s) will need a mixed funding model. Therefore the criteria for block funding apply in this circumstance (ie, ABF for health services, block for TTR).
	ABF for TTR requires development of product classification, scope, a unit of output, and costing. Bilateral agreements for TTR in 2012/13 will be widely variable in identified costs across states. TTR must be progressed towards ABF to ensure it is explicitly funded and not 'squeezed out' by a focus on EP for health services. Only TTR functions in public hospitals will be subject to the new funding arrangements. Variation in TTR cost identification to date between states may be an artefact resulting from different funding approaches, eg: • Block grants based on inputs or outputs • Input teaching loadings • No specific funding (ie, absorbed into general hospital payments).	*9.5.4 What priority should be given to implementing ABF for teaching, training and research in public hospitals?*	It will be critical that costs and outputs are identified accurately and consistently in setting the baseline for 2012/13, and that these unbundled resources are paid (and protected) through block funding agreements. These will then need to have a formula for annual adjustment for cost and volume changes from 2013/14. While a deadline of 2018 has been set to determine the long term funding model for TTR, the Deans believe that urgency must be given to this work because of: • The need to align with implementation of funding changes arising from the Base Funding Review • The need to introduce EP to TTR • The risk of deliberate or accidental 'squeeze out' by movement of health services to ABF and EP. Our submission suggests a timeline for this work.
		How should the developmental work for funding teaching, training and research under ABF be undertaken?	The highly specialised nature of development of TTR product classification, scope, a unit of output, and costing, and its inter-linking with health service ABF and EP will require a

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			close working partnership between IHPA, the hospital (LHN) sector, and the Medical Deans. It may well also require co-ordination with educators of other health professional groups.
		Are there particular tasks that can be undertaken early to improve the transparency of funding for teaching, training and research?	Establishment of such a partnership and a joint work program would be priorities, together with a shared understanding of the developmental pathway, milestones, and transitional arrangements. Other priorities could include: • An international literature review. • Clarification of linkage with the Base Funding Review findings. • Clarification of the intended role of HWA • Identification of the mechanism for compensating for cost and volume growth within the block. Two specific areas of risk should be given early consideration: • Pro bono teaching undertaken in public hospitals will not be recognised in costing and unbundling, ie it will be counted as a health service cost, not a TTR cost. As the pressure comes on hospitals to minimise health service costs, then this pro bono work (considered by senior clinicians as a core part of their role) could be threatened • TTR undertaken in private hospitals (when not publicly funded) will not be recognised.
10.4 Block grants – teaching, training and research	Identifying the efficient cost of TTR is extremely complex because: • Teaching and training is often a 'joint product' • Staffing relationships and contributions are complex Research can also be a joint product with teaching, can be separately funded by external grants, and performance is complex to measure.	*10.6 (Is this a main issue) which needs to be worked on in 2012/13 and beyond?*	As noted above, TTR does require considerable work to move it into the ABF and EP environment. The Medical Deans believe it must be given significant immediate focus in the period between now and July 2013.