Health Q Consulting
ABN 18 527 266 079
www.healthq.com.au
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Evaluation Report

Evaluation of the Private Hospital Stream Program

Department of Health and Aged Care

21 June 2024

Health Q Consulting
Darren Button
E: darren@healthq.com.au
P: +61 412 157326

Acknowledgement of Country

We acknowledge Aboriginal and Torres Strait Islander peoples as the traditional custodians of country throughout Australia, we respect their spiritual relationship with their country, and we recognise their continuing connection to land, waters and community.

We pay our respects to them, their cultures, contributions and Elders past, present and emerging.

Abbreviations/definitions

AIDA	Australian Indigenous Doctor's Association
ABF	Activity Based Funding
Ahpra	Australian Health Practitioner Regulation Agency
AMC	Australian Medical Council
AMS	Aboriginal Medical Services
AMSA	Australian Medical Students Association
BMP	Bonded Medical Program Scheme
CAP	Competent Authority Pathways
CMI	Commonwealth Medical Internships
CMO	Career Medical Officer
COAG	Council of Australian Governments
CSP	Commonwealth Supported Place
DCT/DPET/DPME	Director of Clinical Training or equivalent. The role has a range of titles in different jurisdictions and training sites, including director of prevocational education and training (DPET) or director of prevocational medical education (DPME)
Department or DoHAC	Department of Health and Aged Care
DoHA	Department of Home Affairs
Doctors-in-training (DIT)	Refers to Interns, Resident Medical Officers and Registrars, including those who are undertaking a postgraduate vocational training program leading to the award of a Fellowship from one or more of the medical Colleges.
DVA	Department of Veterans' Affairs
EPAs	Entrustable professional activities - assessments of these EPAs document an interns' level of entrustability, which is an assessor's judgement of how much supervision the intern needs to safely perform the piece of work that has been observed (introduced as part of the new prevocational framework).
EOI	Expression of Interest
FGAM	Foreign graduates of Australian medical schools
FTE	Full time equivalent

GP	General Practitioner
Health Q	Health Q Consulting
HETI	Health Education Training Institute
HMO	Hospital Medical Officer. Also known as 'Resident' or Resident Medical Officer.
IELTS	International English Language Testing System
IMG	International medical graduates – refers to a doctor who: got their degree outside of Australia or New Zealand or enrolled in a degree in Australia or New Zealand as a temporary resident.
JDTP	Junior Doctor Training Program
JMO	Junior Medical Officer
MEU	Medical Education Unit
MEO	Medical Education Officer
MET	Medical Education and Training Data
MMM	Modified Monash Model
NFGP	National Rural Generalist Pathway
NFPMT	National Framework for Prevocational (PGY1 and PGY2) Medical Training
PGY	Postgraduate Year
PHS	Private Hospital Steam
PHS Grantees	Refers collectively to the funded hospitals with Grant agreements and in receipt of funding the PHS Program
PL	Program Logic
PMC	Postgraduate Medical Education Council. The core responsibility of PMCs is the oversight of the education and training of doctors in their first postgraduate year (PGY1).
PSAT	Program Sustainability Assessment Tool
RJDTIF	Rural Junior Doctor Training Innovation Fund
SRHS	Stronger Rural Health Strategy
VMO	Visiting Medical Officer
WACHS	WA Country Health Service

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Executive Summary

Health Q Consulting (Health Q) was appointed in November 2023 by the Department of Health and Aged Care (the Department) to conduct an evaluation of the Private Hospital Stream (PHS) Program.

The Private Hospital Stream

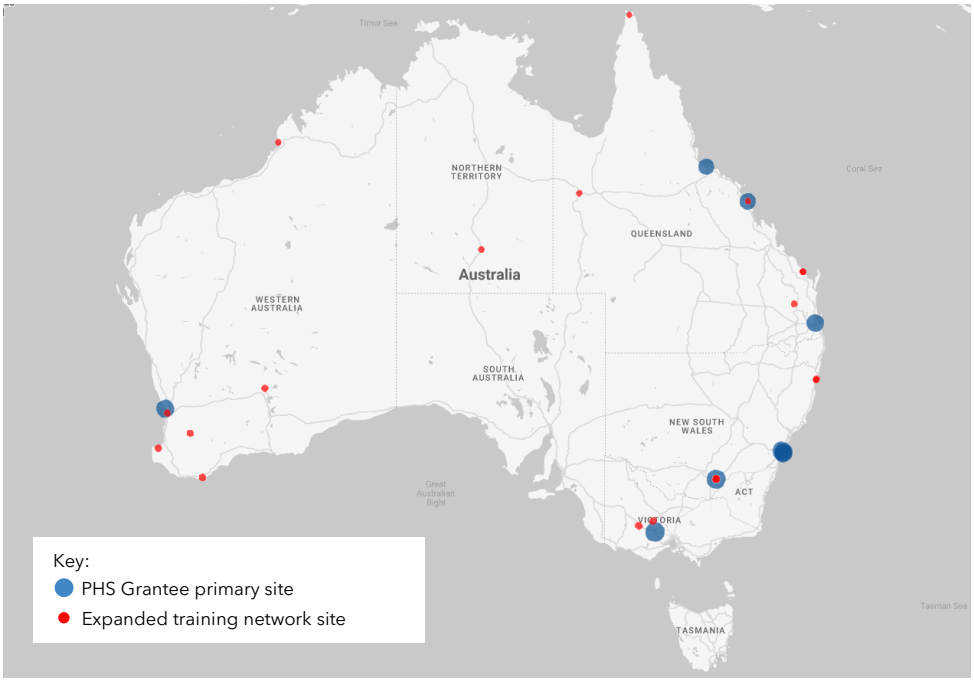
The PHS is part of the broader Junior Doctor Training Program established under the Stronger Rural Health Strategy (SRHS). It supports education, training, and supervision for junior doctors in private hospitals to work in expanded settings, including working in rural communities by funding private hospitals to deliver medical internships. The PHS requires the private hospitals funded under the program (PHS Grantees) to provide at a minimum, one rotation or 0.2 FTE per training place per year in a MM 2 to MM 7 location.

The PHS supports up to **115 intern places** (PGY1) and up to **80 junior doctors** (PGY2, and PGY3) in post graduate years each training year. The total funding provided collectively across all funded hospitals within the PHS (PHS Grantees) is **$24.6 million per annum** (excluding GST, based on 2024 funding). Over the period 2020-2024 the Department has provided $100.5 million (excluding GST) to the PHS Grantees.

To avoid duplication and complement investment by states and territories, the PHS-funded intern (PGY1) places, give priority to international full-fee paying medical graduates from onshore Australian medical schools (Priority One). Other provisionally registered doctors (Priority Two) may be deemed eligible and offered a training place if vacancies occur.

The PHS was designed to foster partnerships between private hospital providers, rural public hospitals, and other training settings working as part of 'expanded training networks.' Nine private hospitals were funded to deliver the PHS, and each developed expanded training networks to ensure the program requirements were met. The location of the nine PHS Grantees and the expanded training network sites are illustrated in Figure 1 below.

Figure 1: Location of PHS Grantees and expanded training network locations



Scope of the evaluation

The overall objective of the evaluation was to understand the appropriateness, efficiency, effectiveness, and impact, of the PHS Program and to provide recommendations to improve the program model in the future. Key features of the evaluation included:

- Development of agreed Evaluation Plan (finalised 22 December 2023).
- Case study visits to each PHS grantee at their principal operating site to understand the local service delivery environment, collaborations, and partnerships within the expanded training network, as well as outputs, achievements, and opportunities to improve the PHS. Through the case study visits the evaluators met with:
  - Management, PHS administrators and supervisors, completing consultations of 72 PHS Grantee representatives in total.
  - Interns and junior doctors that had participated in the PHS program (22 in total).
  - Management and administrators from the expanded training networks (16 in total)
- Consultation with a broad range of stakeholders representing the interests of the Commonwealth, States and Territories, and medical graduates and interns, comprising 30 stakeholders from 12 organisations.
- Analysis of available data on the PHS Program to answer the evaluation questions relating to the appropriateness, efficiency, effectiveness, impact, and sustainability of the PHS Program.
- Production of a Final Evaluation Report (this report) to present the findings of the evaluation and propose recommendations on possible improvements for the PHS Program.

To some extent, the evaluation's timing limited its ability to meet with interns, with the evaluation commissioned on 20 November 2023 and the draft evaluation report due 29 February 2024. At the time of some case study visits, the evaluation could only meet with incoming interns who were two to three weeks into their training year.

In addition, the PHS had not established mechanisms to collect outcome and impact data (beyond junior doctor registration and completion rates). This has limited the ability of the evaluation to access quantitative data and report on the achievement of the PHS objectives (effectiveness and impact). *Consequently, the evaluation was unable to collect evidence to assess the broader community and sector outcomes relating to increased access of primary care services, for First Nation's people, doctors stay on living and working in rural areas beyond PHS support, reduced vacancy rates for rural and remote locations, and improved health outcomes and longer life expectancy for First Nation's people.*

Key findings

Health workforce shortages and maldistribution continue to constrain the equitable delivery of healthcare services to much of the Australian population living outside of metropolitan settings. While Australia has a strong commitment to growing and supporting its domestic medical workforce, internationally qualified doctors supplement the domestic health workforce, filling critical workforce gaps, particularly in many remote and rural locations. In this context the PHS Program continues to have relevance to Australia's rural medical workforce planning and service delivery.

The key findings of the evaluation regarding the appropriateness, efficiency, effectiveness, and impact of the PHS Program and recommendations to improve the program model in the future are presented below.

Environmental factors

In recent years, there has been a significant shift in the supply of graduates relative to the quantum of intern places available, such that all jurisdictions are reporting vacant intern positions. There is an insufficient supply of medical graduates to fill the medical intern places available. This shift has materially impacted the ability of the PHS Program to recruit and has resulted in junior doctors' places being more commonly filled by international medical graduates (IMGs).

In this regard, international students who graduated from an Australian medical school (the equivalent of the Priority One cohort of the PHS) represented 11% of commencements in jurisdictional programs (n=400) in the 2022 year. Data indicates that States and Territories are filling more PGY1 places with this cohort, having grown from 290 places in 2019 (representing 8% of all places) to 400 in 2020 (11% of all places). This increase of 110 places is almost equivalent to the 115 Priority-One places in the PHS Program.

The factors resulting in the increase in demand for medical graduates (and growth in jurisdictional PGY1 places) include increased demand for health services (GP, acute and primary health care), requiring equivalent increases in the medical workforce pipeline. Further changes in industrial relations practices, with increased emphasis on wellbeing and workload, have reduced overtime and required a greater number of junior doctors to provide the same capacity.

At the same time the supply of medical graduates cannot be increased in the short-term (without growth in the IMG places), as it takes approximately 10 to 15 years to fully train a medical doctor, and 75% of university medical students numbers are linked to Commonwealth-funded places and financial budget constraints. Furthermore, the impact of COVID-19 is still being felt, as border restrictions significantly reduced the number of full-fee-paying international students in that year.

Implementation, achievements and impacts of the PHS

The PHS Program has been successful in establishing nine primary junior doctor training programs at private hospitals, supported by an expanded training network of private and public hospitals providing appropriate clinical training, supervision, and experience to junior doctors. The PHS Grantees have developed rotation programs that meet the MM 2+ requirements of the program, and the PHS junior doctors consider that they have been well supported and are confident that the PHS training experience has resulted in positive training and employability outcomes for them and their peers. Medical Training Survey data reported by Ahpra indicates the junior doctors at PHS sites have comparable experiences to those in public hospital settings. All PHS Grantees (and expanded training network sites) considered that the program and the PHS junior doctors made a valuable contribution to their site and organisation. PHS Grantees indicated an appetite to expand their PHS junior doctor numbers, subject to medical graduate supply and funding equivalent to the current arrangements.

Since 2020 the PHS has supported the commencement of 865.7 junior doctor positions with an aggregate completion rate of 90.9%. The most common reason for not completing was the result of an intern leaving the program to take up a public hospital position.

Table 1: Junior doctor PHS program participants by year

Year	PGY1	PGY2	PGY3	TOTAL	Completion rate
2020	117	51	21	189	94%
2021	116	50	26	192	91%
2022	112	56.5	19	187.5	91%
2023	77.2	71	26	174.2	87%
2024	18	85	20	123	NA
TOTAL	440.2	313.5	112	865.7	

National stakeholders consulted by the evaluation considered that private hospitals have a valuable contribution to make to national junior doctor training capacity. State and Territory representatives also acknowledged this contribution but expressed concerns should the program be positioned, in the future, as a competitor for medical graduates.

Until recently, the PHS program has delivered a sufficient number of candidate expressions of interest (EOIs) to supply the PHS program to near full capacity. However, there has been a material shift in the relative supply of and demand for medical graduates, meaning that the PHS has been undersubscribed. This reduction in interns is having material and adverse impact of the effectiveness of the PHS program, which in turn raises questions about the future of the program (and its appropriateness in this changed environment). Some national stakeholders considered the program was no longer appropriate (refer further below).

In respect to candidate eligibility criteria, PHS Grantees considered this as appropriate. In recent years, PHS sites have taken a greater proportion of Priority Two applicants, and while not suggesting Priority Two applicants were inappropriate, Grantees expressed a preference for Priority One graduates.

In terms of appropriateness of the PHS funding provided to PHS Grantees, all grantees observed and acknowledged that the Commonwealth funding represents a contribution only and does not cover all the costs of administering a junior doctor training program. There was a general consensus that the contribution covered the costs of the junior doctor's salaries (and association on-costs) as well as making a contribution to supervision. Despite these comments, all PHS grantees indicated that the benefits outweighed the costs and that the 'business case' for continuing was sound. It is the conclusion of the evaluation that the quantum of PHS funding is appropriate. Future funding rounds should remain a competitive process with annual budgets reflective of pricing indexation to reflect changes in workforce costs.

There are opportunities to improve the efficiency and effectiveness of the program by bringing forward the PHS EOI processes, noting that changes to the PHS EOI processes may have adverse impacts on state and territory programs and will require careful planning and consideration of any unintended consequences at a national workforce level, Other opportunities to improve the PHS include developing a centralised EOI candidate vetting process, and developing standardised and consistent approaches to measuring junior doctors experience and performance indicators.. Exploring a collaboration with Ahpra to commence planning to undertake longitudinal tracking of the PHS cohort, will assist in better understanding the program's impact on regional and remote medical workforce recruitment and retention.

Future of the PHS

The PHS has its origins in the former junior doctor training arrangements in the mid-1990's through the Department of Veteran's Affairs, and more recently, its predecessor program under the health portfolio as the Commonwealth Medical Internships (CMI) program. The PHS Program's underlying design has not varied significantly since its origins as the CMI. The evaluation observes that a program logic has only recently been developed in preparation for the evaluation.

Since the program's inception there have been environmental factors (e.g. industrial relations, training reform, changes in supervision arrangements), policy changes and contemporary evidence that has emerged that could inform the future design. Combined with the current vacancies in the jurisdictional medical graduate programs and undersubscription of the PHS, a small number Commonwealth representatives considered that the program was no longer appropriate and that funding should be re-directed. On balance, more stakeholders (representatives of jurisdictional programs, universities, medical students and PHS grantees) identified opportunities for re-design and realignment that continued to support the roles of private hospitals (maintaining this capacity and capability should medical graduate numbers increase).

In considering opportunities for improvement the evaluation has summarised the programs core objectives in Figure 2.

Figure 2: PHS core design objectives

To optimise future design and impact, the PHS program design (or programs of a similar nature) should consider:

- Longer rural placements and targeting of international medical graduates of rural origin.
- Developing, at a program-level, rural placements that are strategically targeting workforce shortages, rather than the existing general MM 2+ requirements.
- Developing and reporting on evidence of medium to longer-term impact.

The program logic identifies several First Nation's outcomes, including increased access to primary care services for First Nation's people, improved health outcomes and longer life expectancy for First Nation's people, and contribution to reconciliation and Closing the Gap. While there are examples in the expanded training networks where junior doctors are primarily serving First Nation's patients, the design of the program, and the contractual requirements of the PHS Grantee should be more intentional. There is currently no mechanism to achieve these First Nation's outcomes; they are currently opportunistic dependant on the arrangements made and negotiated locally by the PHS Grantee.

Conclusion

The PHS Program has been successful in establishing junior doctor training programs at private hospitals, supported by an expanded training network of private and public hospitals providing appropriate clinical training, supervision, and experience to junior doctors. The evaluation considers core aspects of the program are delivering their intended impact, though these cannot be quantified. If the PHS program continues there are core elements that should be retained:

1. Private hospitals providing junior doctor training.
2. Continuation of junior doctor rotations to rural and remote settings.
3. Continued targeting of international graduates of Australian medical schools and IMGs.

The evaluation has recommended areas of enhancement and redesign. The most challenging aspect of these will be the extent of Commonwealth and jurisdictional engagement required to ensure that the changes are strategic, are complementary to activities under the National Medical Workforce Strategy, and better enhance the rural and remote medical workforce. These will require a program of coordinated effort that leverages the evaluation's recommendations regarding contemporary evidence, the rural generalist pathway, private settings, and an increased emphasis on reporting impact.

Recommendations

The evaluation has identified the following recommendations for consideration:

Recommendation 1 (page 47)	It is recommended that the Department complete forecasts and modelling with respect to medical graduate numbers and medical workforce needs to enable an assessment of the future demand for Priority 1 and Priority 2 junior doctor placements. Without sufficient demand for junior doctors places the PHS Program will become ineffective. Detailed modelling will also enable an informed assessment of the program's appropriateness and relative utility in comparison to programs with similar objectives.
Recommendation 2 (page 47)	It is recommended that the Department commence planning and engagement activities to re-consider the design of the program to ensure the program is complementary to Commonwealth and jurisdictional strategies and programs, contemporary research, and is strategic in targeting geographic areas with critical medical workforce shortages. Outcomes of this may be a redesigned PHS Program, or redirection of existing funding to alterative (or new) programs.
Recommendation 3 (page 48)	It is recommended that, should the PHS program continue, the PHS program design acknowledges that IMGs (Priority Two candidates) will be the larger cohort of PHS participants in the short to medium term and develop promotional material and processes that streamline and support their progression through the program.

Recommendation 4 (page 38)	It is recommended that, should the program continue, a revised program logic be developed for the PHS program. In addition, the PHS, or similar programs should develop a performance measurement framework linked to the program's intended outcomes and impacts and publish performance data. This will improve the awareness and understanding of the program's contribution to junior doctor training as well as rural and remote medical workforce capacity.
Recommendation 5 (page 40)	It is recommended that for junior doctor training programs with rural workforce objectives (like the PHS) that the Department, in collaboration with Ahpra, commence planning to undertake longitudinal tracking of these cohorts to better understand the program's impact on regional and remote medical workforce recruitment and retention. This will provide data to assess program impact and value, as well as representing an opportunity to provide data to inform future medical workforce planning.

In addition, the evaluation has identified the following opportunities for improvement:

a) There is an opportunity to improve the ability of the program to recruit junior doctors by increasing the promotion of the program and bringing forward the timing of the EOI process. This will better position the program to recruit quality candidates, improve the program's reputation and allow more time for IMG clearances. At a minimum, the PHS EOI applications should open at least four weeks earlier (31 August). This will need to be negotiated with states and territories to ensure no detrimental impact on other junior doctor training programs.

b) There is an opportunity to develop enhanced program design elements, embedded in grant agreements, that requires rotations to locations, and in settings, which provide increased medical contacts with First Nation's communities. This would typically require a rotation to a public emergency department in a community where First Nation's people represent at least 5% of the local population. Furthermore, the evaluation considers that AMS may not be an appropriate setting for PGY1 rotations and specific reference to these should be removed from program materials.

c) There is an opportunity to better understand the junior doctor training experience of the PHS cohort through the development and adoption throughout the program of a standardised survey to better understand and benchmark the junior doctor experience.

d) There is an opportunity to reduce duplicative effort of PHS Grantees by sourcing, within the existing funding, a centralised process for validating the eligibility of EOI candidates.

1. Introduction

Health Q Consulting (Health Q) was appointed in November 2023 by the Department of Health and Aged Care (the Department) to conduct an evaluation of the Private Hospital Stream (PHS) Program. This report presents the findings of the evaluation.

The Private Hospital Stream

The PHS is part of the broader Junior Doctor Training Program established under the Stronger Rural Health Strategy (SRHS). It supports education, training, and supervision for junior doctors in private hospitals to work in expanded settings, including working in rural communities by funding private hospitals to deliver medical internships. The PHS has a strong focus on supporting training for junior doctors in regional (MM 2), rural (MM 3 to MM 5) and remote areas (MM 6 to MM 7) as defined in Modified Monash Model (MMM).

The PHS Program has been implemented across several jurisdictions with the most recent tranche of funding being delivered from 2020-2024. It is this period that has been the focus of the evaluation.

History

The PHS has its origins in the former junior doctor training arrangements in the mid-1990s through the Department of Veteran's Affairs, and more recently, following the transfer of the responsibility and budget to the Commonwealth Health portfolio in 2015-16, its predecessor program, the Commonwealth Medical Internships (CMI) program. The program was renamed and operated as the PHS for the first time in 2019. However, what has been consistent across the CMI and the PHS has been:

- a focus on Private Hospitals providing junior doctor training to complement the junior doctor training of the States and Territories,
- junior doctor eligibility being international graduates of either Australian Medical Schools or IMGs, and,
- links to the relevant rural health workforce strategies of the day.

Critical in understanding the PHS role in junior medical training in Australia was the establishment, at the Council of Australian Governments (COAG) meeting of 14 July 2006, for the states and territories agreement to guarantee intern training for medical students in a Commonwealth Supported Place (CSP). Australian-trained medical graduates and overseas-trained doctors cannot obtain general medical registration in Australia without completing an internship (PGY1) year or another appropriately supervised position. This training is still largely undertaken in the public hospital setting. State and territory governments have primary responsibility for the provision of medical internships, as public hospitals are the major employers of interns.

To avoid duplication and complement investment by states and territories, the PHS-funded intern (PGY1) places give priority to international full-fee paying medical graduates from onshore Australian medical schools (Priority One). Other provisionally registered doctors (Priority Two) may be deemed eligible and offered a training place if vacancies occur.

A timeline of key developments impacting the evolution of the PHS is presented in **Appendix A**.

Intern eligibility

The eligibility of international full-fee paying medical graduates (Priority One) and international medical graduates (Priority Two) are described in the program documentation.

The **Priority One** cohort represents final year medical students who are eligible for an internship under the Private Hospital Stream initiative. Final year medical students must meet the following eligibility criteria:

- be a full-fee paying international student completing their medical degree during the current calendar year from an onshore medical school in Australia, having completed all of their medical degree in Australia (short-term elective rotations completed offshore will not exclude applicants provided rotations have university approval),
- have met the Medical Board of Australia's English language proficiency requirements for registration purposes (provisional registration as a medical practitioner cannot be obtained without meeting this standard),
- not be an Australian Citizen, and,
- commit to obtaining an appropriate visa to work in Australia during the internship year (refer to the Department of Home Affairs website for details).

The **Priority Two** cohort represents junior doctors who are provisionally registered doctors who meet the eligibility criteria. Priority Two category applicants will be considered for a Private Hospital Stream internship if the list of Priority One medical graduates has been exhausted and vacant Private Hospital Stream internship positions remain. Priority Two doctors must meet the following eligibility criteria:

- have met the Medical Board of Australia provisional registration requirements as a medical practitioner,
- have met the Medical Board of Australia English language proficiency requirements for registration purposes (provisional registration as a medical practitioner cannot be obtained without meeting this standard), and,
- commit to obtaining an appropriate visa to work in Australia during the internship year (refer to the Department of Home Affairs website for details).

Medical students and junior doctors are not eligible for a placement under the PHS initiative if they have been offered a state or territory internship place for the next calendar year (if the position to be funded is for PGY1); and/or cannot demonstrate that they have met the Medical Board of Australia English language requirements at the time of application for the Private Hospital Stream.

Funded hospitals

The PHS supports up to **115 intern places** (PGY1) and up to **80 junior doctors** (PGY2, and PGY3) in post graduate years each training year. The total funding provided collectively across all funded hospitals within the PHS (PHS Grantees) is $24.6 million per annum (excluding GST, based on 2024 funding). Over the period 2020-2024 the Department has provided $100.5 million (excluding GST) to the PHS Grantees.

The PHS is designed to foster partnerships between private hospital providers, rural public hospitals, and other training settings working as part of an 'expanded training network'. Nine private hospitals were funded to deliver the PHS from 2020 to 2024 (Table 2), noting that St Vincent's Private Hospital Sydney and Mater Hospital Sydney now leverage common administrative support through St

Vincent's Health Australia, and similarly for the Central Queensland and North Queensland contracts which are administered through Mater Misericordiae Limited.

Table 2: Funded hospitals by jurisdiction, location

Hospital/s	Jurisdiction	Primary location	Number of junior doctors funded		
			PGY1	PGY2	PGY3
Calvary Health Care Riverina	NSW	Wagga Wagga	-	4	-
Greenslopes Private Hospital	QLD	Brisbane	34	19	6
Joondalup Hospital	WA	Perth	25	27	10
Mater Misericordiae Ltd [1] – Central Qld	QLD	Mackay/ Bundaberg	22	11	6
Mater Misericordiae Ltd [1] – North Qld	QLD	Townsville	15	-	-
MQ Health (Macquarie University Hospital)	NSW	Sydney	6	-	-
St John of God Ballarat Hospital –	VIC	Ballarat	3	-	-
St Vincent's Private Hospital Sydney[2]	NSW	Sydney	5	-	-
Mater Hospital Sydney[2]	NSW	Sydney	5	-	-
Total			115	61	22
Grand Total Junior Doctors			198		

To be eligible private hospitals must:

- be privately owned and operated by a non-government organisation,
- have the necessary accreditation requirements in place to deliver medical internships to meet the Medical Board of Australia's registration standard,
- provide junior doctors with salaries and conditions equivalent to those that exist in public hospitals in the relevant state or territory, and,
- provide, at a minimum, one rotation or 0.2 FTE per training place per year in a MM 2 to MM 7 location, for each intern (PGY 1), PGY 2 and PGY 3 junior doctor completing an annual training place.

Intern recruitment and placement

The Department is responsible for decisions regarding the internal administration and program management arrangements under the PHS. In addition, the Department has responsibility for undertaking annually, a coordination role through an Expression of Interest process to facilitate medical graduates applying for internships funded through the PHS. This includes:

- the scheduling of intern (PGY1) recruitment rounds,
- advising private hospitals of the periods they will be able to offer PHS intern (PGY 1) places,
- providing private hospitals with an applicant register of PHS interns, applicants for recruitment purposes,

[1] Administered through Mater Misericordiae Limited

[2] Administered through St Vincent's Health Australia

- managing the applicant register of PHS intern applicants,
- liaising with state and territory government intern recruitment authorities to share intern application information and to coordinate the PHS recruitment process to align as closely as possible with state and territory processes. This includes consultation with the National Intern Audit Manager (Health Education and Training Institute) to match applicants who have already received and accepted a State/Territory Government internship offer through rounds 1, 2 and 3, as these applicants are not eligible for the PHS, and,
- participating as a member of the National Medical Intern Data and Management Working Group - established to improve national consistency of intern recruitment and to streamline the process.

PHS-participating private hospitals are responsible for:

- receiving the eligible applicant list from the Department and reviewing eligibility,
- contacting eligible applicants they are interested in short listing for the recruitment process, and,
- if deemed successful, offering PHS internships to eligible applicants.

The recruitment and employment arrangements for participating hospitals seeking to employ PGY2 and 3 junior doctors is determined by each hospital.

Purpose and structure of this document

This Evaluation Report presents the findings of the evaluation of the PHS Program. The structure of the remainder of this document is as follows:

Chapter 2	Presents key background information to inform and understand the environment and policy context in which the PHS operates.
Chapter 3	Presents the scope, methodology and key evaluation processes implemented to ensure the evaluation objectives were met.
Chapter 4	Presents the evaluation findings in respect to the implementation, achievements and impacts of the PHS in the current funding period (January 2020 to December 2023).
Chapter 5	Presents the evaluation findings in respect to future design considerations for the PHS Program.
Chapter 6	Presents the final conclusions from the evaluation as well as the recommendations proposed to improve the program's administration and impact.

2. Background and policy context

This chapter presents key background information to inform and understand the environment and policy context in which the PHS operates.

Junior doctor training in Australia

State and Territory Governments are the primary employers of junior doctors. The term junior doctors in used to describe the cohort of doctors completing their postgraduate, prevocational training, and placements. This section presents background information on junior doctor training relevant PHS Program environment.

Medical interns

An internship in Australia is the period where medical graduates undertake supervised clinical training within an accredited public or private hospital with exposure to a variety of clinical settings. For most medical graduates, it is the first year of employment as a medical practitioner and is referred to as PGY1 (postgraduate year 1).[3]

During internship, students have provisional registration with the Medical Board of Australia. On completion of PGY1, graduates can obtain general medical registration in Australia.

State and territory governments have primary responsibility for the provision of the medical internships. Intern training is guaranteed for Australian medical students through a **Commonwealth Supported Place** (CSP), established by the Council of Australian Governments (COAG) in 2006.

According to a 2021 survey released by Medical Deans Australia and New Zealand;

- 84% of domestic medical students are either Australia citizens, Australian permanent residents, or New Zealand citizens,
- 16% of domestic medical students are international students.

From 2017 to 2021, there was an increase of international students intending to reside and practice in Australia from 69.4% to 85.8%; however, a proportion (14.2%) remain, preferring to practise in other countries.[4]

To avoid duplication and complement investment by states and territories, the **PHS funded internship** (PGY1) places first priority to international full-fee paying medical graduates from onshore Australian medical schools, and second priority to international medical graduates (IMGs). Data on the respective participation of each cohort in the PHS are presented in Chapter 4.

Internship workload and remuneration

An internship involves working 47 weeks throughout the year and completing a minimum of four terms of at least 10 weeks, with a maximum of 25% in one subspecialty and a maximum of 50% in one specialty. Part-time internships must be completed within three years of commencement.

Interns must have some exposure to work outside standard hours, with appropriate supervision, such as night or weekend cover, or backfilling doctors on leave. A minimum of 50% of the year must be

[3] "Internships and Prevocational Framework (2023)." Australian Medical Students' Association, 2023., page 14

[4] "Internships and Prevocational Framework (2023)." Australian Medical Students' Association, 2023., page 21

spent attached to a clinical team and a maximum of 20% spent in service terms (i.e. night shifts or backfilling doctors on leave).[5]

The minimum annual award salary for a PGY1 is $55,849 ($28.26/hour), not including weekend or public holiday rates. The annual intern base salary varies nationally with the lowest at $73,086 in New South Wales to the highest at $83,772 in Queensland.[6]

Internship pathway

A revised 2-year Prevocational Framework is currently being introduced by the Australian Medial Council (AMC), setting the national standard for PGY1 and PGY2. In particular, the new framework requires health services to train and assess doctors in PGY2. Training may be completed in public and/or private hospitals, general practices and community-based facilities. Jobs will specify a minimum PGY level for eligibility.

Based on number of years' experience and specialties, the doctor hierarchy in Australia is as follows: Intern, Registrar, Resident, Consultant.

Table 3: Summary of junior doctor designations

	Purpose	Timing	Registration
PGY1	Work-based generalist training in an accredited intern (PGY1) program.	12 months (47 working weeks) Completion within 3 years if part-time Minimum four terms (of at least 10 weeks)	Known as **'Intern'.** Medical graduates have **provisional registration.**
PGY2	Continuation of broad generalist experience. A small minority of graduates begin specialty training in PGY2.	12 months (47 working weeks) Completion within 4 years if part-time Minimum three terms (of at least 10 weeks)	Known as **'Resident'** Medical graduates are eligible for **general registration** on completion of PGY1.
PGY3+	Allows residents to gain exposure to a selected disciplines and decide on a career pathway. Remuneration increases.	Reflects the number of years since PGY1, and the amount of experience gained.	Known as **'Resident'** (note: there are a number of job titles such as Resident Medical Officer or Hospital Medical Officer. As the years' experience increase, the roles become more senior.)

[5] "Guide to Prevocational Training in Australia for PGY1 and PGY2 Doctors." Australian Medical Council Limited, n.d.

[6] "Internships and Prevocational Framework (2023)." Australian Medical Students' Association, 2023.

Most health services have established medical education units (MEUs) and employ medical education officers (MEOs) to support graduate learning. These roles support prevocational training, liaising with the doctors that are supervising students. A director of clinical training (DCT) or director of postgraduate medical education (DPME) oversees training programs in some cases.

State differences and prioritisation

Some aspects of prevocational training differ between states, territories, and health services, for example, application processes (including prioritisation and allocation systems), industrial arrangements and individual program details (i.e. rotations, education programs).

Each state has developed their own priority lists or category groups. A ballot system is used in NSW, QLD, SA and Tas, whereas a merit-based process is utilised in ACT, VIC, WA, and NT.[7] The number of places available to local university graduates versus international students is determined per state.

Commonwealth supported medical graduates are guaranteed an internship position in their immediate postgraduate year, in the state or territory in which their university is located. International medical graduates (IMGs), who are not Australian or New Zealand citizens or Australian permanent residents, are not guaranteed an internship position and need to apply for additional placements that consider factors such as residency status and English proficiency.

Interstate and International Applicants

Interstate applicants and international medical graduates (IMGs) are allocated at a lower priority or undertake a different allocation process. The below summarises prioritisation by state. [8]

NSW, SA, ACT, WA, NT	Prioritisation of interstate applicants who are Australian/New Zealand citizens or Australian permanent residents before any IMGs.
VIC, TAS	IMGs that attended VIC or Tas based universities are prioritised over interstate applicants who are Australian/New Zealand citizens or Australian permanent residents.
QLD	Merit-based for all interstate applicants and IMGs without considering the applicants' categories.

Supporting internships, and accreditation/quality standards

State and territory postgraduate medical councils (PMCs) appoint accreditation teams, which include prevocational doctors or registrars, to accredit prevocational training programs against national standards criteria.

The Australian Medical Council (AMC) in turn accredits PMCs (in addition accrediting medical schools and specialist colleges). Based on the accreditation team's report, the AMC makes recommendations to the Medical Board of Australia, which then approves the PMCs to accredit training programs.[9]

[7] "Internships and Prevocational Framework (2023)." Australian Medical Students' Association, 2023., page 10

[8] "Internships and Prevocational Framework (2023)." Australian Medical Students' Association, 2023., page 10

[9] "Guide to Prevocational Training in Australia for PGY1 and PGY2 Doctors." Australian Medical Council Limited, n.d.

The below table details the roles and responsibilities of bodies delivering national prevocational training.[10]

Table 1: Roles and responsibilities in prevocational training

Bodies	Role in Prevocational Training
Australian Health Practitioner Regulation Agency (Ahpra)	National regulation of medical profession. Sets registration standards. Registers individual practitioners
Australian Medical Council (AMC)	National standards body for medical education. Develops National Framework for Prevocational Medical Training on behalf of Ahpra (PGY1) and Health Chief Executive Forum (PGY2). Accredits postgraduate medical councils (PMCs)
Postgraduate medical councils (PMCs)	State/territory level accreditation of prevocational programs and terms.
Jurisdictions and health services	Employment of prevocational doctors and development and delivery of prevocational training programs

STATE	PMC
ACT	Canberra Region Medical Education Council (CRMEC)
NSW	Health Education and Training Institute (HETI)
NT	Northern Territory Prevocational Medical Assurance Services (NT PMAS)
QLD	Prevocational Medical Accreditation Queensland (PMAQ)
SA	South Australian Medical Education & Training (SA MET)
TAS	Postgraduate Medical Education Council of Tasmania (PMCT)
VIC	Postgraduate Medical Council of Victoria (PMCV)
WA	Postgraduate Medical Council of Western Australia (PMCWA)

States and Territory PMCs consulted in this evaluation and reported a significant shift in the supply of graduates relative in the intern places available, such that many jurisdictions are reporting vacancy intern positions (i.e. insufficient applications to meet intern places available). More details on this issue are presented below.

The National Medical Workforce Strategy of 2021 - 2031 highlights that rather than a shortage of doctors entering the medical system, there is a geographic maldistribution and inadequate supply, either over or under, of doctors to specialties.

[1010] "Guide to Prevocational Training in Australia for PGY1 and PGY2 Doctors." Australian Medical Council Limited, n.d.

The recent placement numbers and an overview of the application process are provided in **Appendix B**. In summary:

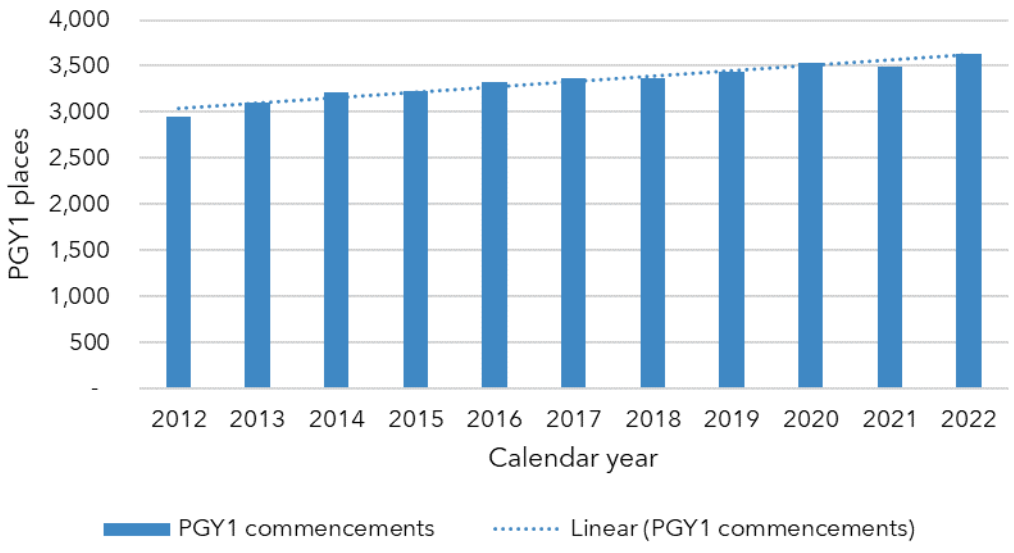
- There are approx. 3,924 places predicted for 2024.
- Applications are generally due in the months of January – June. With 8 June (NSW, Vic, and WA) and 21 March (Qld, NT) being common end dates to the application process. The PHS process occur approximate six months later).

Intern numbers and medical student supply

Junior doctors intern places in Australia are primarily placed through the jurisdictional junior doctor programs managed by each State and Territory. PGY1 intern data is published by the Department as part of the Medical Education and Training (MET) dataset. These most recent intern data currently available is for the 2022 year. This is illustrated in Figure 3. The data indicates that:

- a total of 3,632 PGY1 places were funded by States and Territories (NB Tasmania data was not reported, and the evaluation has included at levels most recently reported). The PHS is relatively small in comparison, with its 115 PGY1 placements representing 3.1% of the jurisdictional programs,
- NSW had the largest cohort, representing 29% of total places; Victoria (24%) and Queensland (22%) are the next largest cohorts,
- there has been continued and significant growth in PGY1 commencements, noting that this data reports commencements only, and does not report available places or vacancies. All states and territories reported that they now have vacant PGY1 places, noting 3,924 places are planned for 2024.

Figure 3: State and Territory PGY1 commencements

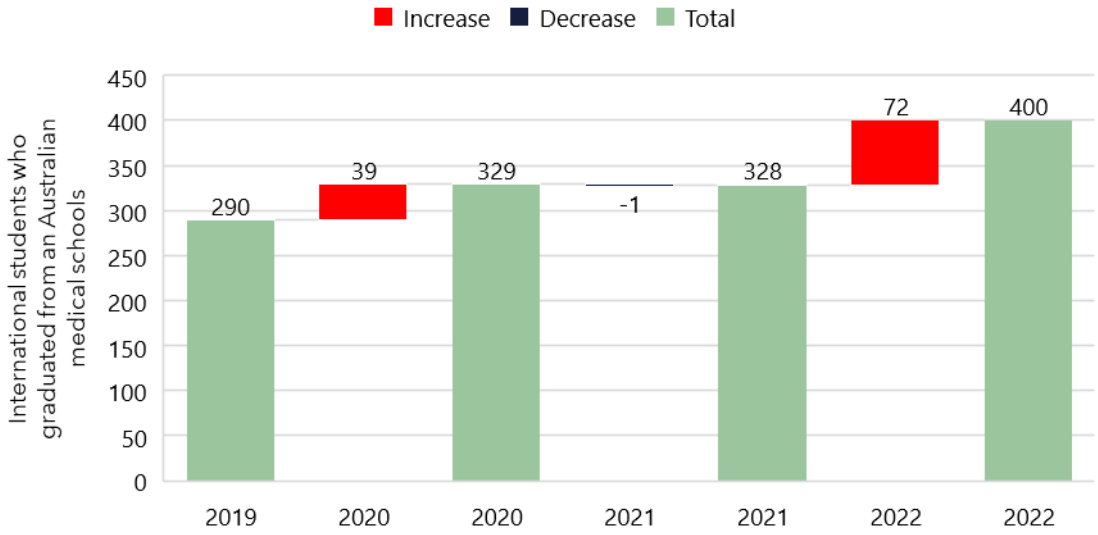


International students who graduated from an Australian medical school (the equivalent of the Priority One cohort of the PHS) represented 11% of commencements jurisdictional programs (n=400) in the 2022 year, with the greatest proportion being placed in NSW (representing 16% of PGY1 commencement in that state). States and Territories are filling more PGY1 places with this cohort, having grown from 290 places in 2019 (representing 8% of all places) to 400 in 2020 (11% of

all places). This increase of 110 places is almost equivalent to the 115 Priority One places in the PHS Program.

The change in numbers of international students who graduated from Australian medical schools in the last three years is presented in Figure 4 below:

Figure 4: PGY1 commencements, Internationals who graduated from an Australian medical school



The reasons for the growth on PGY1 places at a State and Territory level were identified by stakeholders as:

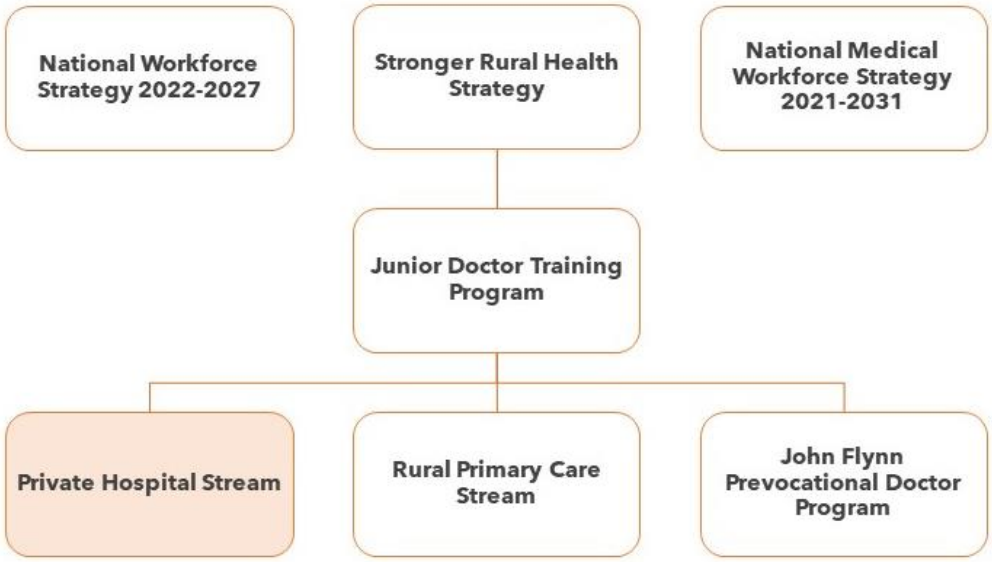
- Increased demand for health services, requiring equivalent increases in the medical workforce pipeline.
- Changes in industrial relations and workforce management practices in respect to interns, with an increased focus on wellbeing and reductions in overtime. One jurisdictional stakeholder noted that five years ago an intern may have effectively worked at a 1.6 FTE workload, and that this is no longer appropriate. That said, analysis of Medical Training Survey (national, profession-wide survey of all doctors in training in Australia, 2023 (n = 22,337)) indicates that workload management continues to be a challenge:
  - Two thirds (64%) of doctors in training reported working more than 40 hours on average per week, including one in 10 (9%) who worked more than 60 hours on average per week.
  - Half of all doctors in training (48%) rated their workload as 'heavy' or 'very heavy'.

  As further improvements are made in junior doctor roster and overtime management, the demand for interns will continue to increase.
- The supply and availability of medical graduates is a critical factor. Stakeholders observed that supply is particularly impacted by the:
  - funding decisions made by Commonwealth in respect to the number of funded University places in respect to the HECS-HELP schemes (53% of 2022 medical student places) and the Bonded Medical Program (BMP) scheme (22% of 2022 medical student places),
  - the timeframes required to train a doctor, with stakeholders observing that it takes 10 to 15 years to fully train a medical doctor locally, and
  - the negative impact of COVID19 border restrictions had on full fee paying international medical student numbers.

Policy context

The PHS Program is guided by several federal policies related to the medical workforce and rural and regional health more broadly, as presented in Figure 5. Some of these policies are discussed in further detail below.

Figure 5: Policy and program landscape



National Medical Workforce Strategy 2021-2031

This Strategy has been developed to guide long-term medical workforce planning across Australia. Spanning 10 years, it is intended to improve access to health care by building a sustainable, highly trained medical workforce, where it is needed most.

The strategy provides recommendations to address some of the issues that medical practitioners and health consumers face, including:

- changing models of care, including the impact of technology,
- the uneven distribution of trainees and medical practitioners across locations and specialties,
- increasing pressures and demands affecting the mental health and wellbeing of the medical workforce,
- the underrepresentation of Aboriginal and Torres Strait Islander medical practitioners across the workforce,
- specialty training numbers not matching current or predicted community need,
- less access to health care services in regional, rural, and remote areas,
- the centralisational of specialist service in large regional centres (hub and spoke models),
- a complicated training and career pathway for medical students and junior doctors, and,
- a lack of data, planning and coordination across governments in the way we train, recruit and support doctors.

The strategy aims to address medical workforce issues by exploring actions that fall under the five key priorities of:

- collaborating on medical workforce planning and design,
- rebalancing the supply and distribution of doctors across specialties and locations,
- reforming medical training pathways,
- building the generalist capability of the medical workforce, and,

- building a flexible and responsive medical workforce.

Stronger Rural Health Strategy

The Stronger Rural Health Strategy (SRHS) is a 10-year strategy from 2018–19 to improve the health of people in Australia through the supply of a quality health workforce that is distributed across the country according to community need. It aims to deliver 3,000 extra doctors and 3,000 extra nurses by 2028.

The SRHS aims to build a sustainable, high-quality health workforce that is distributed across the country according to community need. It focuses on rural and remote communities and other areas that have difficulty attracting doctors, nurses, and other allied health professionals. It includes a range of incentives, targeted funding and bonding arrangements that give doctors more opportunities to train and practice in rural Australia. It also strengthens the role of nurses and allied health professionals to deliver more multidisciplinary, team-based models of primary health care. The SRHS consists of many initiatives organised under three themes (Table 5):

Table 4: SRHS initiatives

Teach	• The Murray–Darling Medical Schools Network • Expansion of the Rural Health Multidisciplinary Training program delivers more rural placements for health students
Train	• **The Junior Doctor Training Program** • Improved access to Australian-trained GPs • Medicare measures • The More Doctors for Rural Australia Program • Streamlining general practice training • Support for Aboriginal and Torres Strait Islander health professional organisations
Recruit and retain	• HeaDS UPP health workforce planning tool • Bonded Medical Program • Workforce Incentive Program • Strengthening the Role of the Nursing Workforce initiative • The Educating the Nurse of the Future initiative • Royal Flying Doctor Service support • Improved targeting of bulk billing incentives • Visas for GPs to manage the growth of the medical workforce

The PHS Program

The PHS is part of the broader Junior Doctor Training Program established under the SRHS discussed above. It supports education, training, and supervision for junior doctors in private hospitals to work in expanded settings, including working in rural communities by funding private hospitals to deliver medical internships. This program has been described in Chapter 1 and is the focus of the evaluation findings present in the balance of this report.

Kruk Review of health practitioner regulator settings

Despite Australia having a strong commitment to growing and supporting its domestic medical workforce, internationally qualified doctors are critical in filling workforce gaps, particularly in many

remote and rural locations. Acknowledging the importance of this workforce, the National Cabinet commissioned an independently led review of Australia's regulatory settings relating to overseas health practitioners. Given the PHS Program's reliance on medical graduates of international origin, the findings of the Kruk review are likely to have ramifications for the PHS Program.

The review covered health practitioner registration, skills and qualification recognition for overseas trained health professionals and international students who have studied in Australia. The review process was to involve consultation with relevant stakeholders to ensure feedback helps deliver the health workforce Australia needs to provide high-quality health services.

The Final Report was published in December 2023 and outlined a suite of reforms for immediate action:

- Remove duplication and align evidentiary requirements so applicants only need to 'tell us once', with information shared across regulators and agencies. Move to a single portal over time where applicants can submit all documentation in one place.
- Enable more cohorts from trusted countries to be 'fast-tracked' through competent authority pathways (CAPs) and transition equivalence assessments for specialist medical graduates from the specialist medical colleges to the Australian Medical Council.
- Better recognition of overseas health practitioners' experience and skills.
- Provide applicants with greater flexibility in demonstrating their English language competency, by aligning our requirements with the UK and NZ, reducing the required score for the writing component to 6.5, but requiring an average International English Language Testing System (IELTS) score of 7 overall and 7 in each of the other three components (reading, speaking, listening).
- Department of Health and Aged Care (DoHAC) to continue workforce supply and demand modelling for medicine (generally and by specialty) and nursing and commence work with states and territories and relevant stakeholders to address gaps in allied health workforce data to facilitate supply and demand modelling in the future.
- Remove or suspend labour market testing requirement for employers sponsoring priority health practitioners on certain visas and broaden the age exemptions for permanent skilled visas to encompass key health practitioners.

3. Evaluation objectives and scope

The chapter presents the scope, methodology and key evaluation processes implemented to ensure the evaluation objectives were met.

Evaluation objective

The overall objective of the evaluation was to understand the appropriateness, efficiency, effectiveness, and impact, of the PHS Program and to provide recommendations to improve the program model in the future.

To ensure a holistic and detailed understanding of the Program, this evaluation included consultation at the local service delivery level as well as data collection and analysis across existing program sites.

The evaluation included the following features:

- an agreed Project Plan, inclusive of a risk management plan,
- an agreed Evaluation Plan for the rigorous evaluation of the PHS Program to support continuous improvement of PHS program,
- case studies and measurement of key performance indicators to assess the current delivery of the PHS program,
- identification of data requirements for the PHS Program evaluation, including the identification of deficiencies in the information currently collected about the program,
- data collection on the PHS Program to answer the evaluation questions relating to the appropriateness, efficiency, effectiveness, impact and sustainability of the PHS program,
- identification of measurable key performance indicators and other metrices that can be used in future evaluation of the PHS Program to assess the performance of each grant recipient,
- Development of a Draft Evaluation Report, inclusive of Program Logic to allow the evaluation's findings to be tested and validated, and,
- a Final Evaluation Report (this report) to propose recommendations on possible improvements for the PHS Program.

Development of the Evaluation Plan

The evaluation design was presented in the Evaluation Plan dated 22 December 2023. This Evaluation Plan was informed by the following processes:

- Project initiation meeting with the Department conducted on 6 December 2023.
- Preliminary consultations with governance-level stakeholders (see **Appendix C** for participants).
- Review of key internal documents and data provided by the Department.
- Initial planning consultations with a sample of funded PHS sites (refer **Appendix C**).
- An Evaluation Plan Workshop was held on 18 December 2023 (see **Appendix C** for attendees).

Program logic model

A crucial first step in any evaluation is the design of a program logic to illustrate the inputs and processes and/or activities of a program, and the associated outputs, outcomes and impacts which are anticipated should activity be delivered according to the model. The program logic model for the PHS Program is presented in **Appendix D**.

Outcomes and impacts measurement

The program logic identified a range of outputs and intended outcomes of the program. Table 5 below presents a comprehensive list of outcomes expected from the program assessed by the evaluation. For ease, these have been grouped into outcome domains.

Outcomes taken directly from the program logic are designated as "**PL**". Any outcomes with the "**HQ**" designation have been identified by the evaluation as outcomes that should be assessed by the evaluation. The evaluation sought data (quantitative and qualitative) to assess the extent to which these outcomes have been achieved. Where relevant data items were not being collected, recommendations will be made to support additional data collection by the Department and hospitals to improve output and outcomes measurement for future program monitoring.

Table 5: Outcomes domains and potential outputs and outcomes measures

Outcome domain	Outcome	Measure
Training outcomes	• Increased rural medical training capacity, including regional, rural and remote private hospitals operating as vertically integrated teaching units for medical students. (**PL**) • Strengthening the junior doctor training pathway in expanded settings, in particular MMM 2-7. (**PL**) • Engagement, cultural safety and cultural appropriateness training as part of the PHS. (**HQ**)	• Training completion data and rates by PHS grantee and MMM locations. • Clinical skills development/assessments. • Engagement with Aboriginal Medical Services within expanded training networks.
Workforce / employment outcomes	• Increased recruitment and retention of junior doctors in Private Hospitals. (**PL**) • Increased and sustainable pipeline of junior doctors in private hospitals located in regional, rural, and remote locations. (**PL**) • Stable service delivery through consistent workforce and capability. (**PL**) • Reduced vacancy rates for rural and remote locations. (**PL)** • Doctors stay on living and working in rural areas beyond PHS support. (**PL**)	• Trending of local vacancy rates. • Conversion rate of training to employment in discipline. • Increase in pool of available trained staff. • Increase in employment retention locally. • Local doctor retention after graduation to work in site/location. • Motivation to remain in discipline and/or location/site.

Outcome domain	Outcome	Measure
Network and partnership outcomes	• Enhanced rural training networks to increase the supply of doctors in training to address current workforce shortages and meet the changing health needs of Australians. (**PL**) • Networks have effective governance and administration and provide a sustainable approach to deliver rural training networks. (**HQ**)	• Sustainable and long-term partnership between Department, hospitals and other local services in network. • Local referral and support pathways established and maintained.

Out of scope outcomes in the program logic

The following outcomes were identified in the program logic but were identified as out of scope for the evaluation (Table 6).

Table 6: Out of scope outcomes

Outcome domain	Outcomes
Community outcomes	• Increased access of primary care services, for First Nation's people. (**PL**) Note: the evaluation did, however, seek to collect baseline data regarding First Nation's service utilisation and PHS engagement.
Primary care delivery outcomes	• Improved quality of care delivery, inclusive of trauma informed, culturally appropriate & safe approaches (where First Nation's doctors and communities are funded). (**PL**)
Workforce outcome	• Opportunities for career progression of funded employees vertically (more senior roles) or horizontally (other relevant/similar roles). (**PL**)
Overall outcomes	• Improved health outcomes and longer life expectancy for First Nation's people. (**PL**) • Contribution to reconciliation and Closing the Gap. (**PL**)

Evaluation domains

The following evaluation domains have been identified for exploration through this consultancy in each hospital (Table 7). In conjunction, existing barriers, enabling factors and opportunities for improvement will be explored for each domain.

Table 7: Evaluation domains

Evaluation Domains	Strategic Findings
Appropriateness 1. Funding model / arrangement 2. Intern recruitment and retention 3. Local need, context, and implementation 4. Training subjects (priority groups) 5. Partnership and networking approach 6. Governance arrangements	Barriers Enabling factors Opportunities for improvement
Effectiveness and impact 7. Training completion outcomes 8. Community outcomes 9. Workforce / employment / economic outcomes	
Efficiency, sustainability, and future design 10. Partnership/network development 11. Local workforce capacity outcomes 12. Financial and operational sustainability 13. Alternative approaches	

To guide the development of the consultation tools and analytical approach, an Evaluation Matrix was developed (**Appendix E**). The matrix aligns with the overarching evaluation and domains presented above, but goes further, to identify associated lines of enquiry (evaluation questions) and points of data collection or data sources, to respond to those lines of enquiry and in turn, inform our evaluation recommendations.

Data collection

Given hospitals involved have been contracted since 2020, the timespan scope for the evaluation will mirror this for data collection and analysis purposes (2020-2024). The evaluation sought access to several existing databases from which key quantitative data was extracted (Table 8).

Table 8: Existing quantitative data sources

Type	Description
Hospital reports and data	• Reports required under the Grant Agreement – Performance Reports – Annual Reports – Other Reports • Medical training and intern surveys completed by Grantees is relation to the PHS cohort • Intern and JMO workforce recruitment and retention data • Intern and JMO completion data
Public data sets	• Medical Education and Training (MET) Data Collection • Medical Training Survey results • Relevant ABS and AIHW data

Type	Description
Dept. Health data sets	• Intern EOI and recruitment data, including applicant register information • Funding data

In addition to the existing data collections, the evaluation undertook data collection across multiple sources.

The PHS had not established mechanisms to collect outcome and impact data (beyond junior doctor registration and completion rates). This has limited the ability of the evaluation to access quantitative data and report on the achievement of the PHS objectives (effectiveness and impact). *Consequently, the evaluation was unable to collect evidence to assess the broader community and sector outcomes relating to increased access of primary care services, for First Nation's people, doctors stay on living and working in rural areas beyond PHS support, reduced vacancy rates for rural and remote locations, and improved health outcomes and longer life expectancy for First Nation's people.*

Case study visits

The evaluation included case study visits to each PHS grantee at their principal operating site to understand the local service delivery environment, collaborations, and partnerships within the expanded training network, as well as outputs, achievements, and opportunities to improve the PHS. The evaluators from Health Q Consulting spent 1 day in each location meeting with a range of relevant stakeholders with respect to the grantee's PHS activities. The dates and attendees are each case study site are presented in **Appendix F**. Through the case studies, the evaluators met with:

- Management, PHS administrators and supervisors, completing consultations of 72 PHS Grantee representatives in total.
- Interns and junior doctors who had participated in the PHS program (22 in total).
- Management and administrators from the expanded training networks (16 in total).

The evaluation's timing limited its ability to meet with interns. The evaluation was commissioned on 20 November 2023 and the draft evaluation report due 29 February 2024. At the time of some case study visits, the evaluation could only meet with incoming interns who were two to three weeks into their training year.

Stakeholder consultation strategy and tool

Through the case study visits and direct approaches the evaluation consulted with a range of stakeholders, summarised in Table 9.

Table 9: Summary of stakeholder consultations

Approach	Stakeholders consulted
Within case study framework	• Site leadership and site-based PHS program managers (initial case study showcase) • Clinical workforce director (face to face, individual consultation) • Education program director (face to face, individual consultation) • Finance business manager (face to face, individual consultation)

Approach	Stakeholders consulted
	• Interns and JMO's (face to face, group consultation) • Supervisors (face to face, group consultation) • Expanded training network partners (telephone or video consultation) Through these consultations, the evaluators met with100 stakeholders.
Broad sector-based consultations	• Strategic stakeholders: – Australian Private Hospitals Association – Australian Medical Students' Association – Higher Education Training Institute – State and Territory Coordination Units – National Workforce Intelligence Data Working Group – Australian Indigenous Doctors Association (AIDA) – Medical Deans Australia and New Zealand – National Rural Health Commissioner • Representations from the Department: – Workforce Division – Health Training Branch – NRGP Implementation Section – Medical Workforce Policy & Strategy – Professional Entry Rural Training (University) – Medical Specialist Training (STP) Through these consultations, the evaluators met with 30 stakeholders from 12 organisations. The stakeholders that participated in the evaluation's consultations are presented in **Appendix G**.

4. Implementation, achievements and impacts of the PHS

This chapter presents the evaluation findings in respect to the implementation, achievements and impacts of the PHS in the current funding period (January 2020 to December 2023).

This chapter's content is limited to the current program outcomes within its current design parameters. The consideration of future design considerations and future directions are presented in Chapter 5.

Program implementation and appropriateness

As presented earlier in the report, the PHS has its origins in the former junior doctor training arrangements in the mid-1990s through the Department of Veteran's Affairs, and more recently, following the transfer of the responsibility and budget to the Commonwealth Health portfolio in 2015-16, its predecessor program, the Commonwealth Medical Internships (CMI) program. The program was renamed and operated as the PHS for the first time in 2019. However, what has been consistent across the CMI and the PHS has been:

- a focus on Private Hospitals providing junior doctor training to complement the junior doctor training of the States and Territories,
- Junior doctor eligibility being international graduates of either Australian Medical Schools or IMGs, and,
- Links to the relevant rural health workforce strategies of the day.

In this sense, the implementation of the PHS (and CMI) predates the current evaluation and funding period.

Funding and costs

Private healthcare providers and private hospitals' primary sources of income comprise private health insurance payments, Medical Benefits Schedule billing (noting patient copayments and fees are a less significant proportion of income). These income sources do not include a supplement or funding component intended to support teaching or training. Each private hospital's decision to provide junior doctor training is made based on a commercial assessment of the relative costs and benefits of providing training.

In recognition of this, funding was provided through the PHS as a "Commonwealth contribution" to enable private hospitals to deliver training to junior doctors. The PHS was not intended to fund the full cost of each training participant. The 2019 Grant opportunity sought competitive bids establishing a maximum grant for FTE that factored in the rurality of the training location (Table 10).

Table 10: Funding contribution (excl GST) in 2019 Grant Opportunity guidelines

MMM Location	PGY 1	PGY 2	PGY 3
MMM 1	Up to $130,000	Up to $120,000	Up to $110,000
MMM 2 – 4	Up to $140,000	Up to $130,000	Up to $120,000
MMM 5 – 7	Up to $150,000	Up to $140,000	Up to $130,000

In terms of appropriateness, all grantees observed and acknowledged that the Commonwealth funding represents a contribution only and does not cover all the costs of administering a junior doctor training program. There was a general consensus that the contribution covered the costs of the junior doctor's salaries (and association on-costs) as well as making a contribution to supervision. Similarly, there was a consensus that the funding did not cover the costs of staff employed to administer the program, travel costs to MM 2+ locations or overhead allocations (for instance, for space or equipment). Despite these comments, all PHS grantees indicated that the benefits outweighed the costs and that the 'business case' for continuing was sound. The key benefits delivered from the PHS grantee are presented later in this report.

The evaluation notes that the accounting for the costs varies by site, and none of the sites were able to present a fully costed assessment of their PHS activities (most commonly overhead, supervision, and travel were not identified, but this did vary). Furthermore, having reviewed the data presented at case studies, and in the funding acquittals, costs incurred by PHS Grantees are all variable. Fixed costs are negligible.

Based on the evidence provided by sites, it is the conclusion of the evaluation that the quantum of PHS funding in appropriate.

Other observations of the evaluation with respect to costs and funding are:

- Not for profit/Charity grantees can take advantage of salary packing benefits, as well as other tax relief in certain jurisdictions resulting in lower employment related costs for-profit grantees.
- The costs of managing and administering a hospital in a rural and remote location is more expensive than in a metropolitan setting. This is a factor of the much smaller scale of rural hospitals, logistical challenges of distance, the typically higher burden of illness, workforce challenges, and the relative lack of supporting local healthcare services.
- All PHS grantees that the 2023 extension and contract variation did not attract any pricing indexation and considered this unreasonable given the increases in salaries of interns and other related program costs.

The total funding provided to hospitals under the PHS is $100.5M, summarised by the financial year below.

Table 11: PHS funding to PHS grantees by financial year

FY2019-20	FY2020-21	FY2021-22	FY2022-23	FY2023-24	Total
$12.3M	$25.5M	$25.8M	$24.6M	$12.3M	$100.5M

Future funding rounds should remain a competitive process with annual budgets reflective of pricing indexation to reflect changes in workforce costs.

Intern eligibility, recruitment, and retention

As presented earlier in this report (Table 2), the PHS was implemented to support 198 junior doctor places across Australia. The geographic dispersion of the available and funded places is heavily concentrated in Queensland (62% of PGY1 places; 57% of all places), Western Australia and New South Wales, as presented in Table 12 below.

Table 12: Established junior doctors' places in the PHS, by jurisdiction

Location	PGY1	PGY2	PGY3	Total	Intern %	Total %
ACT	-	-	-	-	-	-
NSW	16	4	-	20	14%	10%
NT	-	-	-	-	-	-
QLD	71	30	12	113	62%	57%
SA	-	-	-	-	-	-
TAS	-	-	-	-	-	-
VIC	3	-	-	3	3%	2%
WA	25	27	10	62	22%	31%
TOTAL	115	61	22	198	100%	100%

The geographic dispersion varies significantly from the distribution of the Australian population and/or State and Territory junior doctor placements in Australia. The current distribution of PHS places has been significantly influenced by the sector training capability established through the predecessor DVA and CMI programs, as well as the competitive nature of the funding application processes. While this recently established capability has been supported (and perpetuated) by the PHS funding (which is, itself, a broader PHS outcome discussed later in this report), the concentration in a few locations presents a scenario that may indicate a program that would benefit from more strategic direction and design. This is discussed further in Chapter 5.

Medical graduate eligibility

The PHS is available to two defined cohorts of medical graduates comprising:

- International medical students (full-fee paying) who have graduated from an Australian medical school (Priority One), and,
- International medical graduates (Priority Two).

In addition, graduates from the above group are not eligible if they have accepted an internship position from a state or territory government.

Consultation with a broad range of stakeholders considered that this was an appropriate cohort for the PHS Program, with those stakeholders identifying that domestic students were subject to the Commonwealth guarantee and more appropriately recruited through the State and Territories junior doctor training programs. For State and Territory representatives, in particular, there was a strong preference for the PHS not to compete for graduates with the State and Territory programs (discussed further in 'recruitment and placement' below).

The PHS Grantees accept the PHS scope as appropriate. In recent years, PHS sites have taken a greater proportion of Priority Two applicants, and while not suggesting Priority Two applicants were inappropriate, Grantees expressed a preference for Priority One graduates as they generally:

- have a better understanding of the Australian health system,
- have training outcomes and quality consistent with Australian medical school requirements, requiring less intense supervision,
- have stronger English language, and, consequently, communication skills, and,
- have a more established support and friendship network in Australia, simplifying the management of health and wellbeing matters.

Recruitment and placement

The Department, Workforce Training Branch, administers the receipt of junior doctor applications to the PHS on behalf of the program. This is done through the annual expressions of interest (EOI) internship process for junior doctor applicants (for PGY 1 funded places only). The Grantees are responsible for their own recruitment activities for PGY 2 and 3 junior doctors.

Until recently, these processes have delivered a sufficient number of EOIs to supply the PHS program near full capacity. However, as discussed in Chapter 2 there has been a material shift in the relative interest from and demand for medical graduates, meaning that the PHS has been undersubscribed. Consultation with PHS Grantees and PHS interns identified that the **awareness of the PHS is low,** and that greater promotion may result in increased EOIs. Key comments included:

- While the Department hosts a website page and collects and administers the EOI process, it does not promote the PHS to potential applicants or through Medical Schools. The Department advises that this is consistent with program design and that no funding is available for promotion.
- All interns included in the evaluations consulting advised that they heard of the PHS through their social networks via word of mouth. This is despite the efforts of Australian Medical Students Association (AMSA) and PHS grantees (refer next points).
- AMSA advised that they promote the PHS through (and the JDTP) through their International student network.
- PHS Grantees advised that they promote the PHS places available through their individual program through a range of activities, including University expos.

Should the PHS continue, there are opportunities for greater targeting, planning, and coordination with respect to program promotion.

With respect to the **reputation of the program**, the majority of sector stakeholders and interns identified that the PHS was seen by interns as second-best to the State and Territory positions in public hospitals and settings. Two key factors were referenced in this regard:

1. The higher acuity and breadth of experience in the public system was seen as providing a more complete experience, and
2. The timing of the PHS EOI (refer below) was significantly after the offers provided by the States and Territories, giving it the appearance of a program that accepted medical graduates who were unable to find a place in the public system.

While these comments, particularly in relation to the quality of the experience and training, may not be reflective of the PHS program's quality, these issues are clearly impacting the attractiveness of the program and recruitment of medical graduates.

PHS Grantees identified additional recruitment challenges related to the current EOI processes and timing that are potentially negatively impacting recruitment as well as program efficiency and effectiveness. These focused on the timing of the EOI process and the quality of applicants.

With respect to **the timing of the EOI process,** all of the PHS grantees suggested that bringing forward the date for opening the EOI process would be beneficial. However, there was a significant range of views:

- A small number of PHS Grantee sites suggested a small change, such as bringing the EOI process forward four weeks, would significantly improve the ability of the program for international medical graduates (Priority Two) to Finalise visa requirements and obtain the

necessary clearances from Australian Health Practitioner Regulation Agency (Ahpra). All sites have experienced delays in the finalisation of these matters in 2023 and 2024, resulting in delayed starts for IMGs into the PHS. This has impacts on rotation planning and hospital capacity and efficiency. While all acknowledged that Ahpra was closed over Christmas and presumably had a significant increase in IMG applications due to the relative supply of and demand for medical graduates, there was consensus that a small change in timing would have significant benefit.

- In contrast, there was broader support from PHS grantees the timing of the recruitment should be brought forward to coincide with State and Territory processes. This would have a significant benefit for the PHS, in terms of:
  - Making a greater pool of Priority One and Priority Two candidates available.
  - Removing the stigma of the PHS operating as a program that 'mops up' the candidates not good enough to be recruited by the States and Territories.

The evaluation acknowledges that this change would have significant benefits for the PHS and enable it to be better positioned to recruit quality candidates and improve the program's reputation. Most national stakeholders consulted were in agreement with this view. However, States and Territories, while accepting of a small timing change, were not supportive of a change that would see the PHS compete on the same timeframes for medical graduates.

Opportunity for improvement: There is an opportunity to improve the ability of the program to recruit junior doctors by increase the promotion of the program and bringing forward the timing of the EOI process. This will better position the program to recruit quality candidates, improve the program's reputation and allow more time for IMG clearances. At a minimum, the PHS EOI applications should open at least four weeks earlier (31 August). This will need to be negotiated with states and territories to ensure no detrimental impact on other junior doctor training programs.

EOI acceptance and vetting

Apart from the timing and recent shortage of eligible graduates (both discussed earlier), the PHS Grantees generally considered that the EOI acceptance, collation and distribution processes of the Department were effective. A summary of EOIs received from 2020 to 2024 is provided below (Figure 6, Table 14).

Figure 6: PHS EOIs trending 2020 to 2024

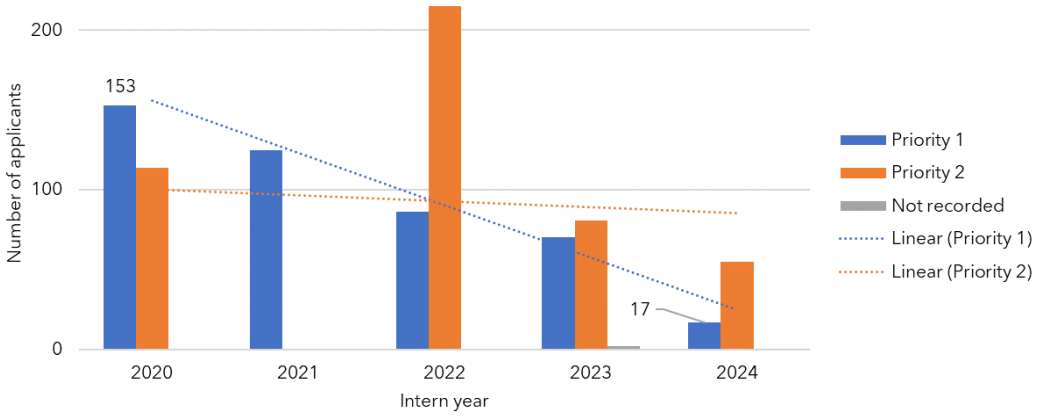


Table 13: PHS EOIs received by year

	2020	2021	2022	2023	2024
EOI's received					
Priority One	153	125	86	70	17
Priority Two	114	-	215	81	55
Not recorded	-	-	-	2	-
Total	267	125	301	153	72
Net EOIs[11]					
Priority One	118	79	55	68	7
Priority Two	114	-	211	71	49
Total	232	79	266	139	56

All PHS Grantees acknowledged the flexibility of the Department and the program in allowing for a variation in the mix (PGY1, PGY2 and PGY3) of junior doctors accepted into the program in response to the intern shortages.

Similarly, all PHS Grantees stated that significant effort goes into vetting, interviewing, and making offers to the PHS candidates each year. Sites noted that the Department does not currently conduct any validation or vetting of the EOIs and that each site completes this independently, at that it is not uncommon to identify ineligible candidates. Given there is potential for all nine PHS sites to vet each candidate, there would be efficiencies gained at a whole program level if the EOIs were validated and vetted only once by a central team and ineligible candidates removed before distribution to PHS sites. The evaluation notes that the contractual arrangements are such that the PHS Grantees have accepted responsibility to ensure applicants are eligible for the program, and that the Department considers that PHS Grantee have accepted this as a cost of participation. Irrespective, some program efficiencies may be gains by pursuing this.

Opportunity for improvement: There is an opportunity to reduce duplicative effort of PHS Grantees by sourcing, within the existing funding, a centralised process for validating the eligibility of EOI candidates

Completion and retention

The table below presents an analysis of PHS commencement and completion in the period 2020 to 2023 (noting 2024 shows commencements only). Analysis of these data indicates that:

- completion rates have remained relatively consistent across these timeframes, and,
- the participation of Priority Two junior doctors has increased being directly linked to the reduction in Priority One EOIs.

[11] Net EOI removes those applications with a status indicting the applicant accepted a jurisdictional offer, withdraw or were eligible. NB a large number of EOI's (ranging from 6 % to 56% depending on the year) have not status recorded, representing a significant limitation on the accuracy of the "net EOI" calculation.

Table 14: PHS commencements and completions

	2020	2021	2022	2023	2024
Contracted	198	198	198	198	198
Commenced	189	192	187.5	171.2	140
Completed	177	175	171	149	NA
Completion rates	94%	91%	91%	87%	NA
Analysis by year (commenced):					
PGY1	117	116	112	77.2	18
PGY2	51	50	56.5	71	85
PGY3	21	26	19	26	20
Total	189	192	187.5	174.2	123
Analysis by priority (commenced):					
Priority One	110	102	78	37.2	4
Priority Two	7	14	34	40	14
Total	117	116	112	77.2	18
Number continuing from previous years					
PGY1	-	-	5	9	4
PGY2	17	22	24	30	16
PGY3	11	18	9	16	11
Total	28	40	33	55	31

As identified above, the PHS program has demonstrated its ability to retain PGY2 and PGY3 junior doctors (noting that only that only four of the nine sites are funded for this cohort). Data for retention beyond PGY3 was not supplied to the evaluation.

Placement experience

The evaluation sought to explore the placement experience of PHS junior doctors through the feedback surveys administered by the PHS Grantee and through interviews with junior doctors as part of the case study visits.

In respect to understanding placement experience the evaluation notes some limitations as follows:

1. The Annual Medical Training Survey, funded and managed by the Medical Board of Australia and Ahpra, does not report data in a way that allows for analysis of the PHS cohort. Discussion with the Department's central data team identified that data from this survey has not previously been made available to the Department. The inclusion of PHS indicators and the release of this data would allow a more effective analysis of the PHS experience as well as allow for comparative analysis both within and external to the program. The evaluation, however, was able to isolate some PHS hospitals and compare to the national results, with the analysis in **Appendix H**.
2. The timing of the evaluation was limited to the months of December 2023 to February 2024. With the Christmas and New Year period impacting planning for case study visits, these visits

generally coincided with the end of the 2023 intern year and commencement of the 2025 training year and limited the number of interns able to be interviewed by the evaluation.

3. While PHS Grantees generally developed and completed their own survey of PHS junior doctors, the evaluation notes that:
    a. Each site developed its own survey tools, limiting the evaluation's attempts to undertake a comparative analysis.
    b. A number of sites did not prepare an analysis of the survey results for internal reporting purposes. As such, rather than being provided with an analysis of results, the evaluation requested copies of individual survey responses.

> **Opportunity for improvement:** There is an opportunity to better understand the junior doctor training experience of the PHS cohort through the development and adoption throughout the program of a standardised survey to better understand and benchmark the junior doctor experience.

Despite these challenges, the evaluation reviewed available survey data and completed interviews with PHS junior doctors. Consistent findings in relation to the junior doctor experience were that:

- Access to the PHS program was challenging. All those consulted stated that that they found out about the program by word of mouth or by chance. In addition, they noted that the EOI process was so long after the jurisdictional recruitment process that they had concerns and fears about how they would progress their careers. Significant relief and gratitude was expressed that a PHS position became available to them.
- Junior doctors consulted considered that the training experience had met their expectations, and they were positive and confident that the training experience will result in positive training and employability outcomes for them and their peers.
- As noted earlier in the report. The junior doctors considered that the rotations to MM 2-7 locations were valuable, provided opportunities for greater responsibility and clinical decision making. For many it demonstrated that they would consider working in a regional location once their training was complete.
- Compared to their peers and contacts working in the public system the junior doctors considered that they had better working conditions (work-life balance), and valued the direct access to the senior supervising consultants and VMOs.
- In terms of opportunities for improvement, some junior doctors indicated challenges in obtaining procedural experience (e.g. suturing).
- IMGs for whom English was a second language reported that it took some time for these to develop their confidence to present their clinical opinions to VMOs.

AMSA noted that, unlike domestic graduates, international graduates (either Priority One or Two) were mostly likely required to move to a new location to participate in the PHS Program (as the majority of the places were in Queensland or Western Australia). This removed them from their newly established social networks and placed a greater risk from social isolation and wellbeing issues. PHS junior doctors consulted by the evaluation considered that their wellbeing was being adequately allowed for and managed by PHS Grantees.

Partnership and networking approach

All PHS Grantees have been successful in developing partnership and networking arrangements to enable:

- adequate rotation, supervision, and experience to ensure appropriate clinical experience in accordance with the program and relevant accreditation requirements, and,
- to meet the MM 2 - MM 7 requirements of the PHS program.

While the specifics of each Grantee's networking and partnership arrangements are unique (refer to Chapter 6 for more information on each Grantee's approach), there are effectively two broad models being adopted:

1. a metropolitan-based (MM 1) private hospital that has developed relationships with one or more MM 2+ hospitals (five of the PHS grantees have networks of this nature),
2. a regional-based (MM 2+) private hospital that has developed relationships with one or more to ensure appropriate clinical rotations (typically to access emergency department experience) to meet accreditations standards (four of the PHS grantees have networks of this nature).

Consultation with Grantees and network partners (the expanded training sites) identified that:

- the partnership and networking arrangements we appropriate to meet the needs of the program,
- there was a perceived need for partnership in terms of areas of common interest and complementary capacity,
- there was a clear goal for the partnership,
- there was a shared understanding of, and commitment to, this goal among all potential partners, and,
- the perceived benefits of the partnership outweighed the perceived costs.

In summary, relationships in place were valued, considered appropriate, and resulted in mutual benefit. The expanded training sites were generally hospitals in rural (and remote locations). The key benefit derived was clinical capacity, which has flow-on impacts on the site's capacity to provide appropriate services for its local community. These remote expanded network sites have become reliant of the clinical capacity provided by the program.

The evaluation observes that the sustainability of the partnership was underpinned by the mutual benefits being derived from the respective partners and the coordinated and well-planned approaches adopted by the PHS Grantee. In general, each partner was responsible for its own costs, and where cited as a challenge, it was not seen as having a material impact on the partnership's sustainability.

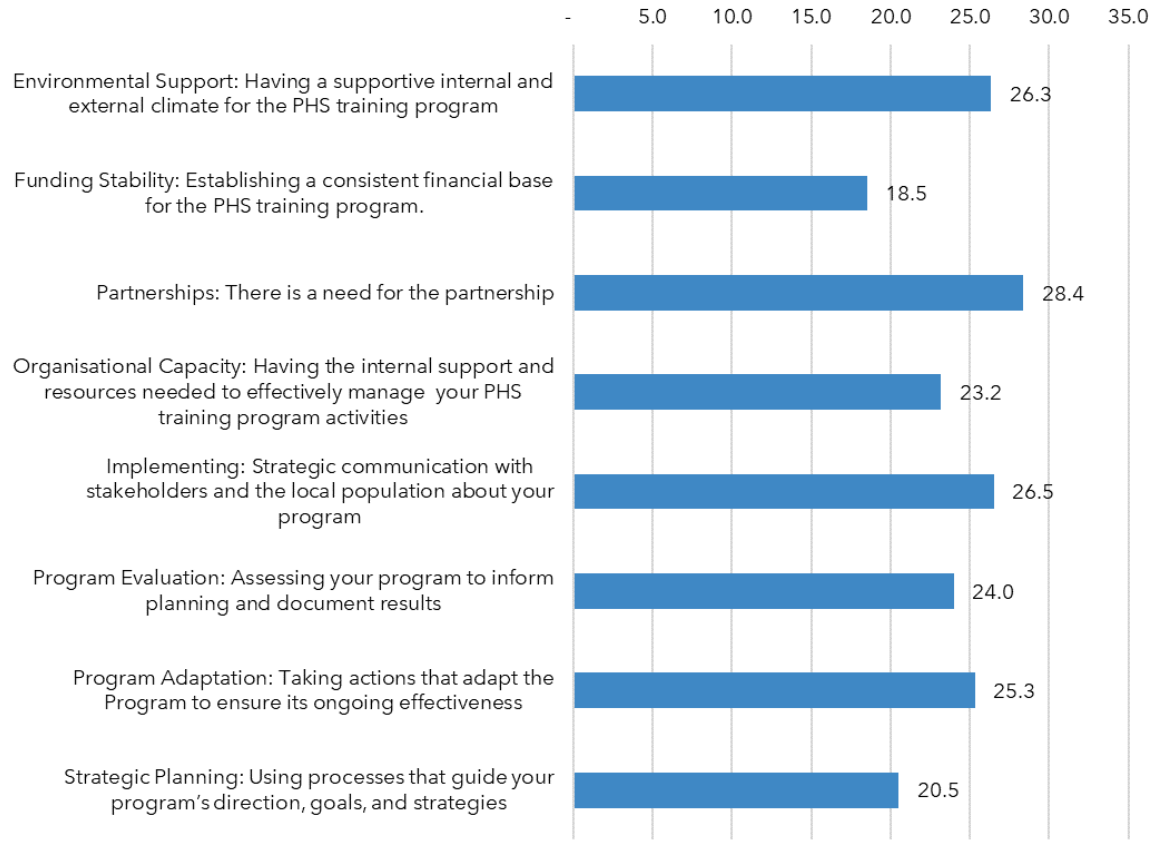
To provide a standardised method of collecting data and assessing the partnerships and sustainability, the evaluation adapted the Program Sustainability Assessment Tool (PSAT), developed by Washington University with the ARVL Centre, and asked PHS expanded training sites to complete as an online survey. The survey instrument included eight domains, each with five questions, with Likert scale scoring of each question ranging from one (to little or no extent) to seven (too a large extent), resulting in a maximum score for each domain of 35 (not applicable response were scored as zero).

As summary of the survey results are presented in the Figure 7 below demonstrating that:

- partnerships and sustainability were strongest in measures relating to internal site and community support (Environmental support) and their being common goals and mutual need for the partnership (Partnerships), and,
- scores were weakest in Funding Stability and Strategic Planning.

Aggregate scores for each question are presented in **Appendix I**.

Figure 7: Aggregated scores for each domain, PSH expanded training site partnership and sustainability survey (n=7)



The evaluation considers that these findings are supported by the consultations. To some extent the partnerships with the expanded training networks were relatively narrow, with a more common arrangement being that a "partner" hospital located in a MMM 2-7 location supported those rotations (to comply with the program requirements). This was akin to a 'supply" relationship, rather than a partnership. However, partners in these arrangements considered the relationship as appropriate and well governed.

Local need, context, and implementation

The private hospital sector represents a significant proportion of the Australian health system, and the role of private hospitals in providing capacity and experience in the training of junior doctors was acknowledged and considered of value by almost all stakeholders consulted.

At a local level, where PHS had developed rotations to MM 2+ locations, these junior doctors were seen as critical to health service capacity and, by default, to the local community. These sites spoke of the recent challenges experienced with the small number of PHS applicants and the vacancies in the PHS program places. These vacancies have placed increased pressure on the site and a need to recruit to fill these gaps (for example, with locums).

Governance arrangements

PHS grantees and expanded training sites considered the program to be appropriately governed and administered.

All PHS Grantees have developed:

- network and partnership forums and communication channels for the program to be appropriately managed and administered,
- clinical and intern supervision models, inclusive of assessment committees, to meet the relevant Medical Training accreditation standards, and,
- junior doctor wellbeing supports (formal and informal).

While not commenting on the PHS Program governance directly, consultation with the State and Territory did identify an opportunity for increased data sharing from the PHS to broaden their understanding of the program's success. That said, this probably leads to the most significant issue, which is that the PHS does not have any standardized data collection systems to measure success. The development of a revised program logic, performance measurement framework and standardised reporting suite would be a significant benefit and would enable the Department to better understand the impact of the program. In addition, it would facilitate improved reporting and information sharing with the relevant stakeholders such as the State and Territories, as well as the National Rural Health Commissioner.

Recommendation: It is recommended that, should the program continue, a revised program logic be developed for the PHS program. In addition, the PHS, or similar programs should develop a performance measurement framework linked to the program's intended outcomes and impacts and publish performance data. This will improve the awareness and understanding of the program's contribution to junior doctor training as well as rural and remote medical workforce capacity.

It is noteworthy that some PHS sites have adopted administrative models that allow junior doctors from varying funding sources to combine and be rostered, trained, and supervised as a single cohort. These include:

- Joondalup. The colocation of the public and private hospital is a key feature allowing for the public and PHS junior doctors cohorts to be managed together..
- St John of God, Ballarat. The PHS interns were combined with the existing Grampians Rural Intern training program to form a larger cohort..

In these examples the junior doctors from the jurisdictional and Commonwealth funded programs are in receipt of an identical training experience. Further, the resultant larger training cohort assist in mitigating some to social isolation and wellbeing risks raised by AMSA (reported earlier in this report).

Effectiveness and impact

This section of the report presents the evaluation findings in respect of the program's effectiveness and impact.

Training completion outcomes

As reported earlier the from 2020 to 2023 the PHS Program has supported 865.7 junior doctors, with commencement and an 89% completion rates.

Progression of junior doctors in completion of their post-graduate requirements is the primary output of the program. In addition, the training rotations underpinning these activities provided these junior doctors to experience at least one rotation in a rural and/or remote setting.

The evaluation's consultations with junior doctors identified that the rural and/or remote experience was of significant value as it facilitated:

- a greater appreciation and understanding of First Nation's health challenges and associated impacts of medical treatment,
- a greater scope of clinical decision-making (for instance, overnight is a busy rural emergency department), and,
- a greater opportunity for hands-on procedural work.

The junior doctors consulted considered that the PHS provided them with appropriate and effective training and were confident that the training experience delivered positive training and employability outcomes for them. All interns expressed gratitude for the opportunity to participate in the PHS and referenced the relief at obtaining a place in the PHS (noting that this is explicitly linked to the PHS recruitment timeframes, as candidates have missed out on places in the State and Territory recruitment processes).

Workforce / employment / economic outcomes

At a national level, until recently, a key outcome of the PHS was that it has absorbed some of the pressure on the public health system to increase clinical training capacity. While medical graduate interest in the PHS has declined, the establishment of the PHS (and its predecessor program, the CMI) has enabled the Private Hospital sector to establish itself as a junior doctor training site. The PHS grantees have developed training programs, supervision and governance models and the capacity required to develop high-quality junior doctors.

Similarly, at a national level, the places available within the PHS provide foreign graduates of Australian medical schools with increased confidence that an intern training place will be available to them in Australia.

At a local level, PHS Grantees were unable to provide data for the evaluation with respect to workforce, employment, or economic outcomes. Some anecdotal commentary supported the notion that PHS junior doctors have returned to their training-hospitals later in their careers. At a hospital and workforce level PHS grantees identified that the outcomes that were derived at a local level were:

- Development of a training culture, having a positive impact on overall workforce engagement and culture
- Improved engagement with Visiting Medical Officers (VMOs) and consultants
- Improved patient monitoring and quality of care

- Improve patient experience and satisfaction.

All PHS Grantees (and expanded training network sites) considered that the program, and the PHS junior doctors, made a valuable contribution to their site and organisation. PHS Grantee indicated an appetite to expand their PHS junior doctors' numbers, subject to medical graduate supply and funding equivalent to the current arrangement.

Data is not available to inform an assessment of the contribution the PHS Program in making to the medium-term or longer-term supply of doctors to rural and remote locations as neither the PHS Grantees nor the Department track PHS participants beyond their involvement in the Program. This represents an opportunity to provide data to inform future medical workforce planning.

Recommendation: It is recommended that for junior doctor training programs with rural workforce objectives (like the PHS) that the Department, in collaboration with Ahpra, commence planning to undertake longitudinal tracking of these cohorts to better understand the program's impact on regional and remote medical workforce recruitment and retention. This will provide data to assess program impact and value, as well as representing an opportunity to provide data to inform future medical workforce planning.

However, the evaluation's consultations with interns explored the extent to which the rotations to MM 2-7 locations were likely to impact a junior doctor's decision about working in a regional location once their training was completed. These interns reported that the MM 2+ rotation had positively influenced their perspectives on continuing their career if placed in a rural setting. When asked if they would working a regional location, the majority said they would consider it, but noted they were early in their careers and that a range of factors, such as chosen specialisation and relationships and family commitments would influence these decisions. The evaluation noted that for many of the IMG's interviewed that they already had families, and while some had moved their families are part of the PHS placement, this was the exception.

Conclusions

The PHS Program has been successful in establishing nine primary junior doctor training programs at private hospitals, supported by an expanded training network of private and public hospitals providing appropriate clinical training, supervision, and experience to junior doctors. The PHS Grantees have developed rotation programs that meet the MM 2+ requirements of the program, and the PHS junior doctors consider that they have been well supported and are confident that the training experience through the PHS has resulted in positive training and employability outcomes for them and their peers.

With respect to the PHS program's ability to deliver on its intended outputs and outcomes, as articulated in the Program Logic, the evaluation reports as follows:

Domain	Measure	Assessment	
Outputs	• 8 private hospitals are funded to subsidise the placement of medical junior doctors.	✓	Achieved
	• An increased number of junior doctors in private hospitals in rural, regional, and remote areas.	✓	Achieved (but limited by COVID and a reduced number of medical graduates)

Domain	Measure	Assessment	
	• PHS supports junior doctors to undertake training in private hospital settings in rural, regional, and remote areas.	✓	Achieved
	• Increased quality medical service provision in rural & remote settings.	✓	Achieved (Data not available but anecdotally supported by Stakeholders)
Short-term outcomes within 1-2 years	<u>Workforce outcomes</u>		
	• Increased recruitment and retention of junior doctors in Private Hospitals.	✓	Achieved (for PHS grantees with PGY1, 2 and 3 cohorts)
	• Increased rural medical training capacity, including regional, rural, and remote private hospitals operating as vertically integrated teaching units for medical students.	✓	Achieved
	• Strengthening the junior doctor training pathway in expanded settings, in particular MMM2-7.	✓	Achieved
	• Enhanced rural training networks to increase the supply of doctors in training to address current workforce shortages and meet the changing health needs of Australians.	✓	Achieved (in a general context as PHS places are enabling Priority One and 2 medical graduates to secure placements that would not otherwise be available to them).
	<u>Community outcomes</u>		
	• Increased access of primary care services, for First Nation's people.	✘	Not achieved. While there are examples of this occurring, the evaluation considers that this is not a core element of the program's outcomes across all sites. *NB the evaluation has made recommendations to require First Nation's medical contacts.*
Long-term outcomes 3+ years	<u>Workforce outcomes</u>		
	• Reduced vacancy rates for rural and remote locations.	?	Unable to be determined. *NB the evaluation has made recommendations to improve data collection and outcomes measurement.*

Domain	Measure	Assessment	
	• Increased capacity of junior doctor training in regional, rural, and remote private hospital settings.	✓	Achieved
	• Increased and sustainable pipeline of junior doctors in private hospitals located in regional, rural and remote locations.	✓	Achieved
	• Stable service delivery through consistent workforce and capability.	✓	Achieved (subject to PHS places continued to be filled)
	• Opportunities for career progression of funded employees vertically (more senior roles) or horizontally (other relevant/similar roles).	✓	Achieved
	• Doctors stay on living and working in rural areas beyond PHS support.	?	Unable to be determined. *NB the evaluation has made recommendations to improve data collection and outcomes measurement.*
	<u>Primary care delivery outcomes</u>		
	• Improved quality of care delivery, inclusive of trauma informed, culturally appropriate & safe approaches (where First Nation's doctors and communities are funded).	✓	Achieved (to some extent)
	<u>Overall outcomes</u>		
	• Improved health outcomes and longer life expectancy for First Nation's people.	?	Unable to be determined, however, if any impact would be negligible. *NB Program attribution in respect to this outcome will not be possible, but the evaluation acknowledges that it is appropriate to include as a long-term outcome (subject to the evaluation's recommendations being adopted).*

Domain	Measure	Assessment	
	• Contribution to reconciliation and Closing the Gap.	?	Unable to be determined. *NB Program attribution in respect to this outcome will not be possible, but the evaluation acknowledges that it is appropriate to include as a long-term outcome (subject to the evaluation's recommendations being adopted).*

5. Program design and future considerations

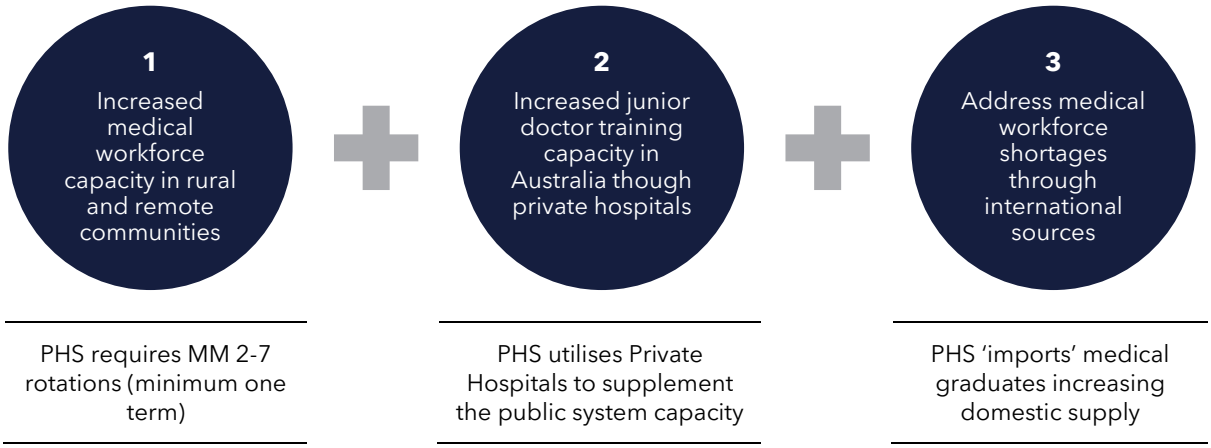
This chapter presents the evaluation findings in respect to future design considerations for the PHS Program.

Review of PHS design intent and policy context

The PHS is part of the broader Junior Doctor Training Program established and funded under the SHRS discussed above. It supports education, training, and supervision for junior doctors in private hospitals to work in expanded settings, including working in rural communities by funding private hospitals to deliver medical internships.

Having considered the intent, funding, and history of the program there are three core objectives of the program (listed in the evaluation's assessment of PHS priorities).

Figure 8: PHS core design objectives



The evaluation notes that the PHS underlying design has not varied significantly since its origins as the CMI. This fact was raised by a number of external stakeholders who suggested that either:

1. The is a more contemporary evidence based that would support a different approach to achieving these outcomes (referring primarily to item 1 in Figure 8), and /or,
2. The junior medical training environment is now significantly different, with a surplus of intern places in the state and territory system. The PHS is a 'solution looking for a problem' (referring primarily to item 2 above).

The continued relevance of and position of each of these three design objectives are considered below.

Medical workforce capacity in rural and remote communities

Health workforce shortages and mal-distribution continue to constrain the equitable delivery of healthcare services to much of the Australian population living outside of metropolitan and adjacent conurbations.

The National Medical Workforce Strategy 2021–2031 presents the most contemporary Australian government document in respect to medical workforce challenges and needs (noting that the SHRS predates the National Medical Workforce Strategy by approximately three years).

Stakeholders consulted identified that are both a Commonwealth and jurisdictional level, there have been programs established to respond to these challenges. In this sense, most consultation participants acknowledge that this is currently just one part of the solution. Furthermore, there are many influences on a graduate's decision to work rurally, particularly during early career stages, when personal circumstances, including relationships with spouses and dependents, are more fluid. A life course approach to influencing rural practice may be beneficial.

Stakeholders generally considered that the PHS was complementary, that is, the PHS was not duplicative or negatively impacting other Commonwealth or jurisdictional programs. In this context, the narrow scope (the Priority One and Priority Two cohorts) and timing of the PHS recruitment after jurisdictions have completed their recruitments were key factors. In considering the role of the PHS, the representatives from WA Health and WA Country Health Service (WACHS) in particular, emphasised the continued need for country placements provided through the PHS, noting that the capacity of hospitals such as Esperance, Broome, and Kalgoorlie, were dependent of these intern places.

Some National stakeholders noted the lack of interest from medical graduates (relative to jurisdictional internships) and undersubscription of the PHS program, and considered that the program was no longer appropriate and that funding should be re-directed.

Should the PHS Program continue, three key themes emerged that questioned the current program design and impact:

1. **Evidence suggests rural placements of at least six months are required to deliver the outcomes.** The PHS does deliver immediate and short-term capacity to rural and regional locations through the current program's rotational requirements. These placements deliver capacity that is highly valued by the destination hospitals.

   However, the National Rural Health Commissioner identified a number of studies[12][13] that indicated rural placements and rural origin allocations will be more likely to deliver the PHS program's intended outcome of reducing medical workforce vacancy rates for rural and remote locations. Furthermore, it was considered that links to rural clinical school education and providing at least six months of their intern year in a rural hospital were key contributing factors.

   Consequently, it was suggested that should the program continue future design should incorporate these elements by extending the length of time required in MM 2+ locations as well as targeting medical graduates (both Priority One and Priority Two) of rural origin in their home country. In contrast, currently the PHS:

   - does not have any rural origin requirements, does not require PGY1 applicants to identify if they are of rural origin, and does not prescribe PGY2 or PGY3 doctors should be recruited or selected.
   - Only requires that each junior doctor must complete at least one rural rotation (MM 2-7 location).

[12] T Sen Gupta et. All, "Positive impacts on rural and regional workforce from the first seven cohorts of James Cook University medica graduates", *Rural and Remote Health 14: 2657. (Online)* (2014)

[13] Matthrew McGrail et. al, "Vocational training of general practitioners in rural locations is critical for the Australian rural medical workforce", *The Medical Journal of Australia 205,* 5 (2016)

2. **At a program-level the MM2+ placements are not strategically targeting shortages**. As noted above, the program requires that each junior doctor must complete at least one rural rotation (MM 2-7 location). The Grant Agreement with PHS Grantees does not place any requirements with respect to a location beyond the MM designation and the need to effectively manage the placements in these sites. Of note, while not in the Grant Agreements, the program website says that through these arrangements, funded hospitals will foster "…partnerships between private hospital providers, rural public hospitals, and other training settings (such as Aboriginal Medical Services) working as part of expanded training networks."[14]

   The PHS grantees have been successful in developing effective partnerships and sustaining their expanded training networks. While this meets their contractual requirements, there are opportunities for the PHS to require more targeted placement requirements, this could include:

   - requiring PHS Grantees to coordinate placement planning through Commonwealth and/or State and Territory PMCs, identifying locations of greatest need, but that are also capable of providing the requirement supervision, experience, and support to meet the training requirements, and,
   - ensuring rural-origin junior doctors are allocated placements that optimise the probability that they may return for a career in a rural location in the future.

   Countering the benefits that may be expected to be derived from changes of this nature, it is acknowledged that the current sites included within the PHS expanded training networks have become somewhat dependent on the junior doctor resources, and that the annual planning and establishing these requirements will increase the administrative effort and burden on PHS Grantees (and perhaps complicating accreditation).

   While not encompassing all the elements above, the implementation of the program at Joondalup has been developed in a way where the WACHS identifies rural placement opportunities in a way that best meets the service needs of the country's health service, providing a more strategic approach.

3. **The PHS is unable to provide evidence of medium to longer-term impact**. Data is not collected by the program to provide evidence that PHS junior doctors return to join the medical workforce in rural and remote locations. This is a gap that affects the program's reputation and standing, particularly considering the evidence presented above that suggests a change in design would be required to be more effective.

Perhaps influential, from a planning perspective, the evaluation notes the 10-year moratorium in Australia for GPs (for IMGs) and its focus on RA3+ locations through the District of Workforce Shortage (DWS) classification. There may be benefits in aligning the location of rural placements to the RA3+ classification.

Further to the above, the National Medical Workforce Strategy (Priority One) seeks improved collaboration across the Commonwealth, states and territories, and private hospitals etc.; there is no evidence of redesign or jurisdictional engagement in the design or implementation of the PHS (with the exception of the WACHS arrangements reported above).

[14] https://www.health.gov.au/our-work/junior-doctor-training-program/private-hospital-stream, last updated 7 February 2024, accesses 24 February 2024

Recommendation: It is recommended that the Department commence planning and engagement activities to re-consider the design of the program to ensure the program is complementary to Commonwealth and jurisdictional strategies and programs, contemporary research, and is strategic in targeting geographic areas with critical medical workforce shortages. Outcomes of this may be a redesigned PHS Program, or redirection of existing funding to alterative (or new) programs.

Increased junior doctor training capacity in Australia through Private Hospitals

A clear intent of the PHS was to provide funding to support the development of junior doctor training capacity and capability in private hospitals. The evaluation has reported in the previous chapter that it considered that this 'capacity building' outcome has been achieved.

The private hospital sector represents a significant proportion of the Australian health system; 58 per cent of all hospitalisations involving surgery occurred in private hospitals in 2016–17. The Australian Bureau of Statistics reports that the sector comprised 657 facilities (including acute care, psychiatric and day hospitals), providing approximately 34,000 beds/chairs, almost 5,000 separations (80% of these had private insurance) and 10,787 patient days each year.

Consultations revealed almost unanimous support for private hospitals providing training for junior doctors noting that the private hospital sector is a significant part of the Australian health system. A key component of junior doctor training should involve getting experience and working in the private sector, as this will provide more well-rounded and educated doctors.

In juxtaposition to the above, there were a large number of stakeholders that considered experience in the public setting was also critical as:

- many considered the private hospital experience may not provide sufficient acuity or complexity,
- the casemix of public hospitals offered a broader range and depth of experiences, and,
- some considered that the supervision and placement opportunities may limit opportunities for independent clinical decision-making.

These comments support, to a large extent, the model currently supported by the PHS.

Where the current design was questioned, it related to considering the extent to which the PHS contracts could be held by a broader range of private health rather than limited to private "hospitals". Given the emphasis of recent strategies and reviews on rural generalist pathways, this would be worth further consideration.

Recommendation: It is recommended that the Department complete forecasts and modelling with respect to medical graduate numbers and medical workforce needs to enable an assessment of the future demand for Priority 1 and Priority 2 junior doctor placements. Without sufficient demand for junior doctors places the PHS Program will become ineffective. Detailed modelling will also enable an informed assessment of the program's appropriateness and relative utility in comparison to programs with similar objectives.

Address medical workforce shortages through international sources

The Australian health system continued to face a shortage of key healthcare practitioners. As reported in the recently released Kruk review, Australia needs more skilled health practitioners, including from overseas, to ensure high-quality, timely and appropriate health care.

The PHS allocates junior doctor places (PGY1, PGY2 and PGY3) only to medical graduates who are not Australian citizens, representing full fee-paying graduates of Australian medical schools, or international medical graduates.

Data reported by Department identifies that 85.8% of full fee-paying graduates stay in Australia to continue their medical practice, demonstrating that the focus on international sources for the PHS continues to align to Commonwealth strategy and is supported by data.

As reported earlier, the supply of full-fee-paying graduates has reduced in recent years. However, this has allowed greater capacity for IMGs (Priority Two). This report has previously presented commentary on the factors underlying these changes, and while these factors may take 5 - 10 years to reverse, there is strong support from the Medical Deans Australia and New Zealand (the peak body representing professional entry-level medical education, training and research in Australia and New Zealand) that the places provided by the PHS will be an important destinations for full fee paying graduates.

In respect to Priority Two candidates some PHS Grantees expressed that the program could consider pathways for limited registration IMGs and the development of program into a work-based assessment location.

Should IMGs continue to be the primary applicants on PHS places in the short term, this will have impacts on PHS Grantees, as all grantees have confirmed that IMGs take additional recruitment efforts, increased supervision, and require additional support to manage their well-being.

Recommendation: It is recommended that, should the PHS program continue, the PHS program design acknowledges that IMGs (Priority Two candidates) will be the larger cohort of PHS participants in the short to medium term and develop promotional material and processes that streamline and support their progression through the program.

Elements of the program logic not supported by the current design

The program logic (**Appendix D**) does include other intended outcomes from the PHS which the evaluation considers are not supported through the program mechanisms, implementation, or the contractual obligations of PHS Grantees. As a result, these outcomes are more tenuous and are more consequential than intentionally achieved. These are considered below:

First Nation's outcomes

The program logic identifies a number of First Nation's outcomes, including increased access to primary care services for First Nation's people, improved health outcomes and longer life expectancy for First Nation's people, and contribution to reconciliation and Closing the Gap. From a design perspective, private hospitals would not be considered services that would be high degrees of service utilisation by First Nations peoples. In 2018–19, in non-remote areas, 21% of Indigenous Australians aged 15 and over were covered by private health insurance (similar to 20% in 2012–13), compared with 58% of non-Indigenous Australians. From July 2017 to June 2019, 12% of

hospitalisations with a procedure recorded for Indigenous Australians occurred in private hospitals, compared with 51% for non-Indigenous Australians.[15] This is supported by the data provided by PHS Grantees in the case studies.

The outcomes presented in the program logic were presumably linked to the requirement for intern rotations to MM 2+ settings. However, placement in MM 2+ locations, especially in private hospitals in those settings, does not guarantee increased experience in supporting First Nation's patients. For example, Calvary Wagga Wagga reported that 3.1% of admissions (n= 440) in the 2023 calendar year were for patients identifying as Aboriginal and Torres Strait Islander.

While there are examples in the expanding training networks where junior doctors are primarily serving First Nation's patients, the design of the program, and the contractual requirements of the PHS Grantee would need to be more intentional. There is currently no mechanism to achieve the First Nation's outcomes; they are more opportunistic depending on the arrangements made and negotiated by the PHS Grantee.

The evaluation's consultation with the Australian Indigenous Doctor's Association (AIDA) discussed the barriers that may exist in respect to establishing intern rotations to Aboriginal Medical Services. The primary barrier identified related to the difficulties in securing regular and reliable access to supervision. AIDA indicate rotations to these services would be most suitable for PGY3 who have greater experience. In addition, it was recommended that the skills of junior doctors sent to these services should have an emphasis on a range of presentations common to Aboriginal Medical Services, such as paediatrics, chronic disease, emergency care, etc. This may require junior doctors to have completed a number of terms that equip them with sufficient foundational skills for engaging with the clientele, which could require AMS rotations to occur later in training programs regardless of supervisory requirements.

Opportunity for improvement: There is an opportunity to develop enhanced program design elements, embedded in grant agreements, that requires rotations to locations, and in settings, which provide increased medical contacts with First Nation's communities. This would typically require a rotation to a public emergency department in a community where First Nation's people represent at least 5% of the local population. Furthermore, the evaluation considers that AMS may not be an appropriate setting for PGY1 rotations and specific reference to these should be removed from program materials.

Regulatory and contextual changes

There are recent developments that will also need consideration in respect to future design:

- Development and progress of Rural Generalist pathways.
- The new National Prevocational Framework.

[15] https://www.indigenoushpf.gov.au/measures/3-14-access-services-compared-with-need#findings, (updated 6 February 2023), accessed 24 February 2024

Rural Generalist pathways

Rural generalists are general practitioners with extended scope who provide primary care services and emergency medicine care and have additional training and skills in a sub-specialty field. They can provide care in community and hospital settings.

There have been significant advances in the establishment of rural generalism since the transition of the CMI to the PHS, including:

- In 2019, the Commonwealth provided $62.2m to advance the first stage of the development of the National Rural Generalist Pathway (NRGP).
- Commonwealth and jurisdictional governments have established the NRGP Recognition Taskforce, NRGP Strategic Council and the NRGP Jurisdictional Implementation Forum.
- In late 2023, a submission was made to the Australian Medical Council for recognition of Rural Generalist Medicine as a specialised field with the specialty of General practice.

Consultations with jurisdictions identified that rural generalist pathways are being progressed as critical elements of rural and remote medical workforce strategies. In the case of the Ballarat PHS Grantee (St John of God), the PHS trainees have been combined with the East Grampians Health Service Victorian Rural Generalist Program interns to form a single cohort of junior doctors receiving identical training, supervision, and support.

The strengthening and establishment of rural generalist pathways across Australia provide new opportunities for the PHS to establish a program design that leverages contemporary approaches to rural internships and practice. Planning and coordination activities with the NRGP Jurisdictional Implementation Forum could provide access to expertise that would enable more coordinated outcomes. The PHS Program engage with the NRGP Jurisdictional Implementation Forum to consider the extent to which inclusion of rural generalist partnerships and expanded training pathways would strengthen PHS program outcomes while complementing jurisdictional rural generalist programs.

New National Prevocational Framework

The revised National Framework for Prevocational Medical Training is currently being implemented across Australia, with implementation expected in 2024 for PGY1, and 2024 or 2025 for PGY2. The new framework establishes a two-year training and assessment requirement for prevocational training programs. Key observations on the evaluation regarding impacts for the PHS grantees were:

- Training and assessment requirement expanded to PGY2 (with a shift towards 'outcomes' rather than clinical placement) but note that general registration still occurs at the end PGY1.
- New entrustable professional activities that describe key work (focus on clinical training) and assessment of the EPAs (increase opportunities for feedback based on observed clinical practice).
- Mandated term supervisor training (to be implemented within three years).
- New and strengthened Aboriginal and Torres Strait Islander standards - Indigenous health, medical graduates are expected to understand and describe the factors that contribute to the health and wellbeing of Aboriginal and Torres Strait Islander peoples, including history, spirituality, and relationship to land, diversity of cultures and communities, language, epidemiology, social and political determinants of health and health experiences. They are also expected to demonstrate effective and culturally competent communication and care for Aboriginal and Torres Strait Islander peoples.

- Strengthened wellbeing standards - This includes having a sound understanding of efficient and equitable rostering practices, including rostering methodology, wellbeing, and fatigue management.

PHS Grantees and stakeholders, more generally, considered that these changes were unlikely to have a material impact on the PHS Program. PHS Grantees indicated that some additional administrative costs and increased supervision and assessment effort would be required.

It should be noted that for most PHS sites, interns are offered a single-year contract only to allow them to complete PGY1 and obtain general registration with Ahpra, and this remains unchanged. In contrast, jurisdictions offer multi-year contracts. The prevocational framework changes to a two-year training requirement may further weaken medical graduates' views of the relative position on PHS intern opportunities. Strategies to mitigate these risks would require the PHS site to commit to longer-term contracts (whether or not funded through the PHS) or for the PHS Program design to increase the number of PGY2 positions. It is the view of the evaluation that it is too early in the implementation process to make a recommendation in this regard. Further, the other recommendations made by the evaluation are likely to be more impactful.

The PHS Program may need to monitor the impact that the implementation of National Framework for Prevocational Medical Training has on the demand for PHS intern places so that it can position the program to respond in a timely manner

A revised program logic model

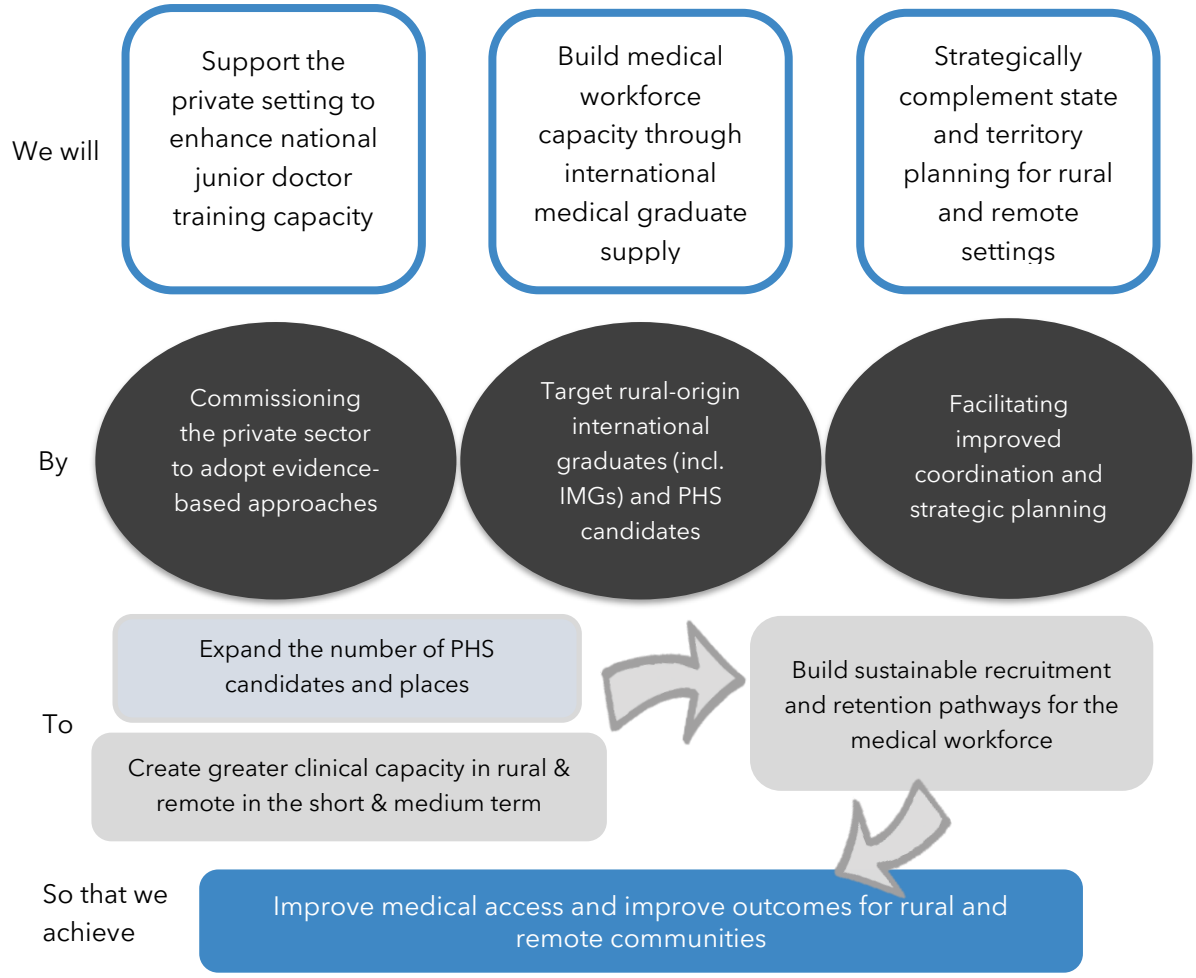
As reported above there are elements of the current PHS program that are recommended to be retained:

1. Private hospitals providing junior doctor training.
2. Continuation of junior doctor rotations to rural and remote settings.
3. Continued targeting of international graduates of Australian medical schools and IMGs.

However, the evaluation has also recommended areas of enhancement and redesign. The most challenging aspect of these will be the extent of Commonwealth and jurisdictional engagement required to ensure that the changes are strategic, are complementary to activities under the National Medical Workforce Strategy, and better enhance the rural and remote medical workforce. These will require a program of coordinate effort that leverages the evaluation's recommendations regarding contemporary evidence, the rural generalist pathway, private settings, and an increased emphasis of reporting impact.

Consequently, it is not possible for the evaluation to develop a detailed revised program logic. However, at a strategic level the following is proposed in Figure 9 as a framework for more detailed development.

Figure 9: High level indicative program logic to inform future design



Conclusion

The evaluation considers core aspects of the program are delivering their intended impact, though these cannot be quantified. If the PHS program continues there are core elements that should be retained:

1. Private hospitals providing junior doctor training.
2. Continuation of junior doctor rotations to rural and remote settings.
3. Continued targeting of international graduates of Australian medical schools and IMGs.

However, to optimise future design and impact the PHS program needs to consider:

- Longer rural placements and targeting of international medical graduates of rural origin.
- Developing, at a program-level, rural placements that are strategically targeting workforce shortages, rather than the existing general MM 2+ requirements.
- Developing and reporting on evidence of medium to longer-term impact.

6. Summary of findings

This chapter presents the final conclusions from the evaluation as well as the recommendations proposed to improve the program's administration and impact.

Key findings

Health Q Consulting (Health Q) was appointed in November 2023 by the Department of Health and Aged Care (the Department) to conduct an evaluation of the Private Hospital Stream (PHS) Program.

The overall objective of the evaluation was to understand the appropriateness, efficiency, effectiveness, and impact, of the PHS Program and to provide recommendations to improve the program model in the future. However, the PHS had not established mechanisms to collect outcome and impact data (beyond junior doctor registration and completion rates). This has limited the ability of the evaluation to access quantitative data and report on the achievement of the PHS objectives (effectiveness and impact).

In recent years, there has been a significant shift in the supply of graduates relative to the quantum of intern places available, such that all jurisdictions are reporting vacant intern positions. There is an insufficient supply of medical graduates to fill the medical intern places available. This shift has materially impacted the ability of the PHS Program to recruit and has resulted in junior doctors' places being more commonly filled by international medical graduates (IMGs).

Despite these challenges, the PHS Program has been successful in establishing junior doctor training programs at private hospitals, supported by an expanded training network of private and public hospitals providing appropriate clinical training, supervision, and experience to junior doctors. The evaluation considers core aspects of the program are delivering their intended impact, though these cannot be quantified. If the PHS program continues there are core elements that should be retained:

1. Private hospitals providing junior doctor training.
2. Continuation of junior doctor rotations to rural and remote settings.
3. Continued targeting of international graduates of Australian medical schools and IMGs.

The evaluation has also recommended areas of enhancement and redesign that respond to changes in the external environment, changing Government policy and the evolving evidence base.

Appendix A – Key developments timeline

2006	2014	2015	2018	2019	2021	2022	2024
At the Council of Australian Governments (COAG) meeting, states and territories agreed to guarantee intern training for medical students through **Commonwealth Supported Places (CSP).**	The **Commonwealth Medical Internships (CMI) program** was introduced in 2014 to increase the number of internship positions available for international students. (Former repatriation hospital program funded by **Department of Veterans' Affairs** (DVA))	**Review of Medical Intern Training**, commissioned by the Australian Health Ministers Advisory Council. (Internships had not been subject to a full review since 1988). Commonwealth funding to Ramsay Hospitals for JMO training was transferred from the **Veterans' Affairs portfolio to Health as part of the 2015-16 Budget.**	Australian Government's **Health Stronger Rural Health Strategy** (10 year plan) - centrepiece of the Department of Health's 2018–19 Federal Budget.	The **Junior Doctor Training Program (JDTP) - Private Hospital Scheme** consolidates the following programs: Rural Junior Doctor Training Innovation Fund (RJDTIF), Junior Medical Officer (JMO) Program, Commonwealth Medical Internships (CMI) initiative.	**The National Medical Workforce Strategy of 2021 – 2031** is released. **John Flynn Program** established as part of the 2021-2022 budget, streamlining rural primary care medical training.	National Cabinet announced an independent **'Kruk review'** of Australia's regulatory settings, covering: health practitioner registration, skill and qualification recognition for overseas trained health professionals and international students who have studied in Australia. **The National Framework for Prevocational Medial Training Review** was completed.	Implementation of changes recommended in the **National Framework for Prevocational Medial Training Review.** PGY1 changes are to be implemented in 2024. PGY2 may be implemented in either 2024 or 2025.

Appendix B - National Internship opportunities and governing bodies

State	ACT	NSW	NT	QLD
2023 projected internships	95	1100	50	805
2024 projected internships	95	1,135.5	65	862
Overview of application process		Applications through the Medical Intern Recruitment Campaign – NSW Health Careers Portal. RPR uses a merit-based recruitment process	Online application	Centralised NT Job portal
Key dates		8 May 2023 – Closing 8 June 2023	7 March 2023 – Closing 21 March 2023	Open 7 March 2023 – closed 21 March 2023
Rural specific programs		Rural preferential recruitment (RPR) Pathway	No dedicated rural internship programs however, NT has strong focus on generalism in their training programs.	Queensland Rural Generalist Pathway Darling Downs Hospital and Health Service
Managing body /organisation	Canberra Health Services	Health Education and Training Institute (HETI)	Northern Territory Prevocational Medical Assurance Services (NT PMAS)	Queensland Health

State	SA	TAS	VIC	WA
2023 projected internships	301	92	891	390
2024 projected internships	311	105	960.5	390
Overview of application process	Rural Pathway - Must meet eligibility criteria and have preference for a Country Health SA site.	Tasmanian Jobs Website	PMCV Allocation and Placement Service (APS) website. Candidates register to participate in the Victorian Intern Match, via the APS. VRGP – merit-based selection process	Application through PMCWA – centralised recruitment process. advertised through JobsWA, with applications being accepted through MedJobsWA.
Key dates		January 2023	8 May – Closing 8June 2023	8 May 2023 – Closing 8 June 2023
Rural specific programs	Rural Intern Pathway – introduced in 2018, seeking applicants who are suitable and have a preference for working in a remote location.	Since 2017, the Department of Health has provided funding to develop rural primary care rotations for interns in Tasmania through the Rural Junior Doctor Training Innovation Fund.	Victorian Rural Generalist Program (VRGP)	
Managing body /organisation	South Australian Medical Education & Training (SA MET)	Tasmanian Department of Health	Postgraduate Medical Council of Victoria (PMCV)	PMCWA (Postgraduate Medical Council of WA)

Information collated from:

- "The Official Guide to the 2024 Internship Year." Australian Medical Students' Association, 2023.
- Llewellyn, Anthony. "Become An Intern In Australia 2024 Clinical Year Guide." Advance med for career doctors, April 24, 2023. https://advancemed.com.au/intern-in-australia-application-guide-2024/.

Appendix C – Stakeholders informing evaluation design

The participants involved in consultation informing the design of the evaluation framework are presented in the table below.

Stakeholder	Role
Project Initiation meeting and/or subsequent planning meetings	
Alexis Mohay	A/g Assistant Secretary, Health Training Branch
Murray Newman	Director, NRGP Implementation Section, Program Director
Rhia Buick	Assistant Director, NRGP Implementation Section, Program Manager
Kasia Skawinski	NRGP Implementation Section, Program Manager
Emma Tokley [16]	Assistant Director, National Rural Generalist Pathway (NRGP) Implementation Section
Daniel Thomas	National Rural Generalist Pathway (NRGP) Implementation Section
Evaluation Plan workshop	
Murray Newman	Director, NRGP Implementation Section, Program Director
Kasia Skawinski	NRGP Implementation Section, Program Manager
Emma Tokley [17]	Assistant Director, National Rural Generalist Pathway (NRGP) Implementation Section
Daniel Thomas	National Rural Generalist Pathway (NRGP) Implementation Section
Representations for PHS Grantees (initial planning consultations)	
Olivia Paton	Director of Clinical Education, Mater Misericordiae Ltd
Mark Lee	Director of Prevocational Education and Training, M Health Pty Ltd
Michelle Karsdorp	Medical Education Officer, Joondalup Hospital Pty Limited
Australian Medical Students' Association	
Allen Xiao	President 2024 (incoming)
Gabrielle Dewsbury	Vice President 2023 (outgoing)
Jade Guitera	Vice President 2024 (incoming)

[16] Did not participate in the Initiation Meeting, but attended the subsequent meeting of 13 December 2023

Appendix D - Draft Program Logic

The Private Hospital Stream (PHS) of the Junior Doctor Training Program aims to:

- Expand training places in the private hospital sector, with a strong focus on supporting training for junior doctors in rural, regional and remote areas in the Modified Monash Model (MMM2-7)
- Foster partnerships between private hospital providers, rural public hospitals and other training settings (such as Aboriginal Medical Services) working as part of expanded training networks; and
- Increase national capacity to deliver medical internships supporting junior doctors to work in expanded settings.

Context	Inputs	Activities	Outputs	Short-term outcomes within 1-2 years	Long-term outcomes 3+ years

• The Private Hospital Stream (PHS) Program has existed in one form or another, for more than 20 years. Formerly known as the Commonwealth Medical Internship (CMI), Additional Medical Internship (AMI) (2013 only) and prior to that Junior Medical Officer (JMO) Program. The PHS as it's now known, commenced in 2019 with an open Grant Opportunity.
• Currently, the Department funds 8 private hospital providers, delivery PHS funded training rotations over 9 private hospital sites. Current Grant Agreements will expire on 31 March 2023.
• The PHS is well established and well regarded by stakeholders.
• There are two priority categories for PHS funded internship places. They are:
  ○ **Priority 1** - international full fee-paying medical graduates from onshore Australian medical schools; and
  ○ **Priority 2** - other provisionally registered doctors may be deemed eligible and offered a training place if vacancies occur.
• The number of Priority One candidates applying through the PHS EOI in 2021, 2022 and 2023 has declined in comparison to the previous years. Anecdotal evidence suggests this is a result of COVID-19 impacts and an increase in offers from State and Territory Governments.
	Financial inputs
	• PHS program funding of $103.9 million over five years (2019-2020 to 2023-24).
	• Funding contribution to enable providers to deliver training to junior doctors in accordance with the relevant professional standards.
	Infrastructure
	• private hospitals, rural hospitals and other training settings infrastructure (such as Aboriginal Medical Services).
	Policy settings
	• National Medical Workforce Strategy 2021-31.
	• National Workforce Strategy 2022-2027.
	• Stronger Rural Health Strategy
	• Independent review of health practitioner regulator settings "Kruk Review".
		Program administration
		Department of Health & Aged Care
		• Grant Allocation & Grant Opportunity Guidelines (GOGs).
		• Grant Agreements
		• Program planning, management, and monitoring.
		• Program review.
		Health Education and Training Institute
		• National oversight and coordination of state-based junior doctor training.
		• National coordination and conduit between state-based and private hospital training places.
		Funded private hospital activities
		• Develop & implement recruitment processes to engage medical graduates and prevocational doctors under the PHS program.
		• Program planning and management.
		• Facilitate access to education/training.
		• Provide performance reports every 6 months.
		• Undertake eligibility checks for PHS junior doctors.
		Funded junior doctor activities
		• Active engagement in employment placement.
		• Apply & participate in education/training that supports delivery of junior doctor training in private hospitals.
			• 8 private hospitals are funded to subsidise the placement of medical junior doctors.
			• An increased number of junior doctors in private hospitals in rural, regional and remote areas.
			• PHS supports junior doctors to undertake training in private hospital settings in rural, regional and remote areas.
			• Increased quality medical service provision in rural & remote settings.
				Workforce outcomes
				• increased recruitment and retention of junior doctors in Private Hospitals.
				• increased rural medical training capacity, including regional, rural and remote private hospitals operating as vertically integrated teaching units for medical students.
				• strengthening the junior doctor training pathway in expanded settings, in particular MMM2-7.
				• enhanced rural training networks to increase the supply of doctors in training to address current workforce shortages and meet the changing health needs of Australians.
				Community outcomes
				• Increased access of primary care services, for First Nations people.
					Workforce outcomes
					• Reduced vacancy rates for rural and remote locations
					• Increased capacity of junior doctor training in regional, rural and remote private hospital settings.
					• Increased and sustainable pipeline of junior doctors in private hospitals located in regional, rural and remote locations.
					• Stable service delivery through consistent workforce and capability.
					• Opportunities for career progression of funded employees vertically (more senior roles) or horizontally (other relevant/similar roles).
					• Doctors stay on living and working in rural areas beyond PHS support.
					Primary care delivery outcomes
					• Improved quality of care delivery, inclusive of trauma informed, culturally appropriate & safe approaches (where First Nations doctors and communities are funded).
					Overall outcomes
					• Improved health outcomes and longer life expectancy for First Nations people.
					• Contribution to reconciliation and Closing the Gap.

Appendix E - Evaluation lines of enquiry

Table 15: Evaluation Matrix

Lines of Enquiry	Data Sources / Analytical Techniques					
	Stakeholder interviews	Program / hospital data	Case studies	Network & Partnerships Matrix	Public data	PSAT
Evaluation Domain 1: Appropriateness						
1. To what extent has the PHS model been implemented in accordance with its intended design in each hospital?	✓		✓			
2. To what extent does the model differ across hospitals or are tailored to accommodate for local context and needs?	✓		✓	✓		✓
3. How accessible has the program been for junior doctors?		✓			✓	
4. Are the target trainees and disciplines appropriate to meet local needs? What is missing?			✓			
5. What local and strategic governance processes have been implemented and how effective are these?	✓		✓			
6. To what extent does each model meet best practice standards for this model of training in each site?	✓		✓			
7. What is the current experience of local practices and services with respect to rural health workforce training, recruitment, quality, and retention?	✓		✓	✓		
8. To what extent do Junior Doctors who have commenced their training feel confident that their experience will result in positive training and employability outcomes for themselves and their peers?		✓	✓			
9. To what extent have successful and sustainable local training networks and partnerships been established in each site?			✓	✓		✓

Lines of Enquiry	Data Sources / Analytical Techniques					
	Stakeholder interviews	Program / hospital data	Case studies	Network & Partnerships Matrix	Public data	PSAT
10. To what extent have networks been developed with Aboriginal Medical Services?			✓	✓		
11. What have been the barriers and factors critical to the success of implementing a clinically and educationally appropriate and best practice training model?			✓			
12. What are the opportunities to improve the delivery of an appropriate training model?	✓	✓	✓			
Evaluation Domain 2: Effectiveness and impact						
13. To what extent have the program's activities been effective? Consider: – Recruitment and allocation processes – State and Territory intern coordination – Intern and rotation management – Broader program governance and administration (at grantee and whole of program)	✓	✓	✓	✓	✓	
14. What have been the major achievements in the past four years?	✓	✓	✓			
15. What has been the experience of the training for Junior Doctors so far?		✓	✓			
16. What outcomes are evident for the trainees, hospitals, local community, health workforce, economy?	✓	✓	✓			
17. What is the experience of PHS sites in successfully engaging with First Nations populations? (consider service utilisation and cultural safety)		✓	✓			
18. Are any unexpected or unanticipated outcomes evident?	✓	✓	✓			
19. What are the barriers and factors critical to the success of sound training outcomes?	✓	✓	✓			
20. What are the barriers and factors critical to the success of workforce outcomes?	✓	✓	✓			
21. What are the opportunities to improve outcomes and impact of the program?	✓	✓	✓	✓		

Lines of Enquiry	Data Sources / Analytical Techniques					
	Stakeholder interviews	Program / hospital data	Case studies	Network & Partnerships Matrix	Public data	PSAT
Evaluation Domain 3: Efficiency, sustainability and future design						
22. Has the program been delivered efficiently and sustainably? (including, within budget)	✓	✓	✓			
23. What have been the barriers and factors critical to efficient service delivery?	✓		✓	✓		✓
24. What are the opportunities to improve efficient and sustainable delivery of training for Junior Doctors?	✓		✓	✓		✓
25. How well does the partnership arrangement between the Department and each hospital function? Does it support sustainability of the model?	✓	✓	✓			
26. Is the current model still contemporary to meet need? What should any future model or funding arrangement look like should changes be required?	✓		✓			
27. What elements of the PHS will need to change with the implementation of the National Framework for Prevocational Medical Training?	✓		✓			

Appendix F – Case study participants

Table 16: Case study participants

Site (date of visit)	Stakeholders consulted		
	Case study visit	Junior doctors	Broader training network
Calvary Health Care Riverina (25 January 2024)	Jacquelyn Hilton (General Manager) Brooke Wichman (JMO Manager) Michael Morris (Director of Finance) Annette Somerville (Recruitment Manager) Michelle Cuthbert (Medical Admin Officer) Professor Gerard Carroll (Clinical Team) Professor David Gallagher (DPET)	2	Dr Malcolm Pell (St Vincent Private Hospital)
Greenslopes Private Hospital (18 January 2024)	James Cafaro, Executive Director of Medical Services Maria Ancajas, Medical Services Manager Justin Greenwell, CEO Liam Mason, Acting Commercial Manager Tomas Coe, Medical Education Officer Dr Gerard Connors, Cardiologist	3	Dr Marlow Coates, Executive Director of Medical Services, Bamaga & Thursday Island Dr Anna Carswell, Director of Clinical Training, Goondiwindi Dr Peter Stickler , Director of Clinical Training, Kingaroy Annabel Tyne, Senior Medical Education Officer, Alice Springs Hospital

Site (date of visit)	Stakeholders consulted		
	Case study visit	Junior doctors	Broader training network
Joondalup Hospital (15 February 2024)	Dr Kevin Hartley – Director Medical Services Dr Cathy Vaughan - Deputy Director Medical Services DMS Kim Box - Manager Medical Administration Niamh Connolly - Finance Manager Elly Sullivan – Director of Finance Dr Sue Davel - Director Postgraduate Medical Education Michelle Karsdorp – Medical Education Officer	2	Dr Francis Lee, Director Medical Services, Hollywood Hospital Nicole Barbarich, Manager Medical Education, WA Country Health Service Sonya Barkovic, Medical Education Officer, WA Country Health Service
Mater Misericordiae Limited – Central Queensland (22 February 2024)	Karen Wade (General Manager MPHM) Catherine Hackney (General Manager - MPHB) Chris Went (Executive Director Regional Health) Olivia Paton (Direction Medical Education and Workforce) Nikki Steemson (Medical Education Coordinator MPHB) Mary Gardam (Principal Medical Officer) Jared Rafael (Finance & Operations Manager)Laura Neilson (Finance & Operations Manager MPHB) Rachel Aspinall (Financial Accountant) Dr David Mackrill (Clinical Lead MPHM) Dr Shengyang (Leo) Liao (Supervisor – MPHB) Dr Martin Strahan (Supervisor – MPHB)	3	Dr Stephen Lambert (Director Clinical Training (DCT) – MHHS) Dean Lynch (Manager Medical Education Unit – MHHS, Mackay Base Hospital) Dr Vanessa Greig (Director Clinical Training (DCT) – WBHHS) Mark Dixon (Director of Medical Services – WBHHS)

Site (date of visit)	Stakeholders consulted		
	Case study visit	Junior doctors	Broader training network
Mater Misericordiae Limited – North Queensland (20 February 2024)	Anna Olsen, General Manager MPHT Chris Went, Executive Direction Regional Health Dr Mike Beckmann, Chief Medical Officer Olivia Paton, Direction Medical Education and Workforce Mark Cathcart, Finance & Operations Manager MPHT Kate McKenzie, Principal Medical Education Officer MPHT Emily Stringini, Management Accountant MPHT Renee Washington, Business Analyst – Finance NQ Dr Kiran Hazratwala – Director Clinical Training MPHT Dr Phil Gaudin, MEC Chair, Emergency Specialist/VMO Beth Hickson, Medical Education Officer MPHT Brittany Young, Medication Education Coordinator MPHT Rebecca Jones, JCU Medical Training Coordinator	3	David Herron, Senior Medical Education Officer THHS (Townsville University Hospital)

Site (date of visit)	Stakeholders consulted		
	Case study visit	Junior doctors	Broader training network
MQ Health (Macquarie University Hospital) (15 February 2024)	Walter Kmet (CEO MUH and Clinical Services) Natalie Sequeira (Director, Academic Health Strategy) Dr Mark Lee (Director of Clinical Training) Associate Professor Taj Saghaie (Deputy Director Medical Services) Professor Alvin Ing (Clinical Program Head of the Cardiovascular and Respiratory program) Narelle Shanahan (Director, Finance) Associate Professor Veronica Preda (Endocrinology Supervisor) Associate Professor Sumit Raniga (Orthopaedic) Alicia Speer (Clinical Workforce Officer) Jamie Loy (Clinical Workforce Coordinator)	4	Coffs Harbour Health Campus (includes Emergency Department)
St John of God Ballarat Hospital (1 February 2024)	Tari Jensen, Executive Assistant, Medical Services, East Grampians Health Service Kim Lane, Grampians Region VRGP Coordinator, Medical Services Tony Roberts, Director Finance, East Grampians Health Service Director Medical Services (DMS) - SJoG – Vincent Russell Clinical postgrad. program/education supervisor – Andrew Dean	1	None

Site (date of visit)	Stakeholders consulted		
	Case study visit	Junior doctors	Broader training network
St Vincent's Private Hospital Sydney (12 February 2024)	Dr Malcolm Pell, JMO Manager Andrew Mereau, Acting General Manager Belinda MacNamara, Learning & Development Coordinator Dr Merrin Thanopoulos, Senior CMO, JMO Education Coordinator A/Prof Justin Roe, DPET Dr Sue Coulshed, Nephrology Professor Fran Boyle, Haematology & Oncology, Director Medical Services	2	Annette Somerville, Calvary Wagga Wagga
Mater Hospital Sydney (13 February 2024)	Dr Malcom Pell, Dr Malcolm Pell, JMO Manager Dr Matt Wall, Director of Clinical Services Lauren Evans, Clinical Administrative Coordinator Leah Hammond, Assistant Director Clinical Services Professor Abdullah Omari, DPET Mr Karl Nguyen,Chief Financial Officer Prof Nigel Biggs, ENT Surgeon Dr Jacob Fairhall, Neurosurgeon Dr Gary Galambos, Psychiatrist	2	Annette Somerville, Calvary Wagga Wagga
Total participants	72 representatives	22	16 representatives

Appendix G - Stakeholders consulted

Table 17: Stakeholders consulted

Organisation	Participant	Count
Australian Private Hospitals Association (APHA)	Lucy Cheetham, Director of Policy & Research	1
Higher Education Training Institute (HETI)/ National Workforce Intelligence Data Working Group	Dr Linda Macpherson, A/Director Workforce Strategy and Culture, Workforce Planning and Talent Development Branch, NSW Ministry of Health	1
Australian Medical Student Association	Gabrielle Dewsbury, Outgoing 2023 President Allen Xiao, Incoming 2024 President Jade Guitera, Incoming 2024 Vice President	3
Australian Medical Student Association, International Student Network	Jacqueline Tan, Outgoing 2023 International Student Network Chair Winnie Theresa, Incoming 2024 International Student Network Chair	2
Australian Indigenous Doctors Association (AIDA)	Simone Raye, President	1
Medical Deans Australia and New Zealand	Professor Kirsty Forrest, Treasurer (Dean of Medicine, Bond University) Dr Brendan McQuillan, Member (Dean of Medical School, University of WA) Helen Craig, Chief Executive Officer	3
National Rural Health Commissioner	Professor Ruth Stewart, National Rural Health Commissioner	1
Department of Health and Aged Care	Murray Newman, Director, NRGP Implementation Section, Program Director Rhia Buick, Assistant Director, NRGP Implementation Section, Program Manager Valerie Ramsperger, Medical Workforce Policy & Strategy, Director, Health Workforce Division Douglas Hay, Professional Entry Rural Training, Health Workforce Division Adj Professor Andrew Singer, Principal Medical Adviser	5
NSW Health representatives	Kathryn Vaughan, Program Manager – Allocation, Accreditation & Faculty Dr Jo Burnand, Deputy Medical Director NSW Health Education and Training Institute	2

Organisation	Participant	Count
WA Health representatives	Dr Tony Robins Dr Graeme Maguire, Director of Medical Education, WA Country Health Service Nicole Barbarich, Manager Medical Education, WA Country Health Service Sonya Barkovic, Medical Education Officer, WA Country Health Service	4
Tasmanian representatives	Helen Mulcahy, Manager, Service Development , Tasmanian Department of Health and Human Services Matthew Spotswood, Senior Registrar (Department of Critical Care Medicine), Royal Hobart Hospital Andrew Conrad, Principal Advisor Medical Workforce, Health Workforce Planning Unit, Clinical Quality, Regulation and Accreditation (CQRA), Department of Health - Tasmania Elspeth Harrison David Ladyman	5
Queensland representatives	Shane Green, Principal Policy Officer, Queensland Health Megan Crawford, Director, Medical Advisory and Prevocational Accreditation Unit, Queensland Health	2
Total stakeholders		30
Total organisations		12

Appendix H – 2023 Medical Training Survey comparison

The 2023 Medical Training Survey (MTS) in Australia provides insights into the quality of medical training for doctors in training. More than half of Australia's doctors in training (approximately 54.5%) participated in the 2023 MTS, making it a significant profession-wide longitudinal survey. The results highlighted quality improvements with certain aspects of medical training, specifically that supervision, orientation, education and patient safety training had improved. The results for 2023 are generally consistent with previous years, with some small but statistically significant variations.

The chart below provides a comparison of the PHS participating hospitals (to the extent surveys were submitted by interns) to 'All hospitals". The term "selected hospitals" refers to the PHS Grantee sites.

The data from Figure 10 suggests varying degrees of agreement or disagreement with training and workplace recommendations among selected hospitals and all hospitals surveyed. For selected hospitals, a notable portion of respondents neither agreed nor disagreed with both training and workplace recommendations (35% for training and 53% for workplace). Additionally, a significant proportion of respondents agreed or strongly agreed with both training (24% agree, 12% strongly agree) and workplace recommendations (24% agree, 12% strongly agree). This indicates a generally positive sentiment towards training and workplace conditions in selected hospitals. Conversely, for all hospitals, the sentiment appears slightly less positive, with fewer respondents strongly agreeing with recommendations compared to selected hospitals (29% strongly agree for training, 31% for workplace). However, the majority still either agreed or strongly agreed with both training (48% agree) and workplace recommendations (47% agree).

Figure 10: Comparisons regard survey results on recommending training and workplace

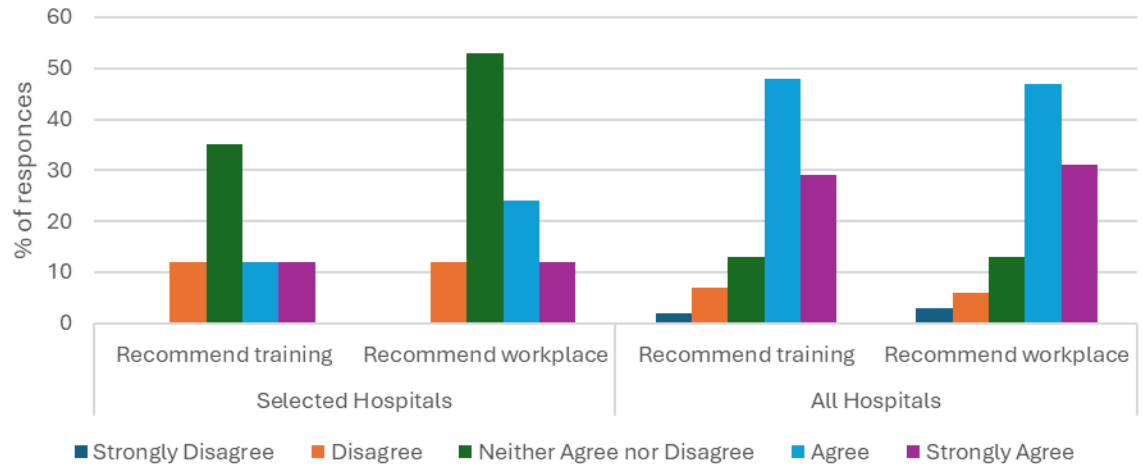
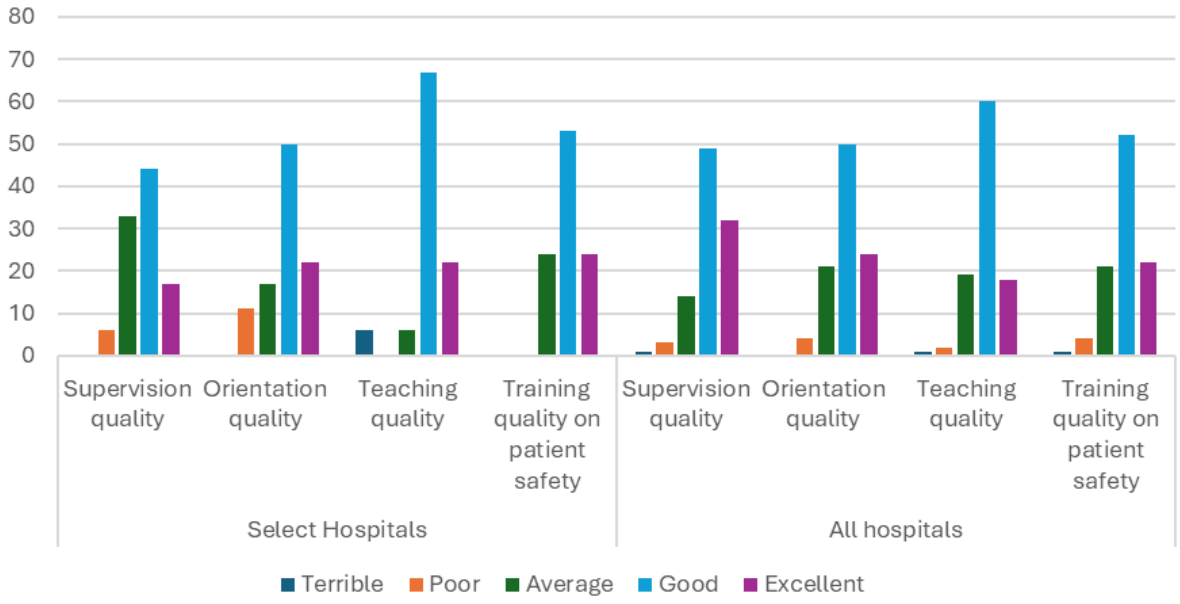


Figure 2 illustrates perceptions of supervision, orientation, teaching, and training on patient safety across select hospitals and all hospitals surveyed. Notably, in select hospitals generally positive sentiments towards these aspects was reported. In contrast, in all hospitals surveyed, while supervision and orientation quality also generally garnered positive ratings, there were a few instances of dissatisfaction. The majority of respondents in both select hospitals and all hospitals rated the quality of supervision, orientation, teaching, and training on patient safety as either "Good" or "Excellent," indicating an overall positive perception of these aspects.

Figure 11: Quality of training and supervision



Appendix I – Expanded training network survey results

Table 18: Aggregate scores for each question, PHS expanded training site partnership and sustainability survey (n=7)

	To little or no extent						To a very great extent	
	1	2	3	4	5	6	7	N/A
Environmental Support: Having a supportive internal and external climate for the PHS training program								
Champions exist who strongly support the PHS training program.	-	-	-	17%	-	33%	50%	-
The PHS training program. has strong champions with the ability to garner resources.	-	-	-	17%	17%	17%	50%	-
The PHS training program. has leadership support from within the larger organization.	-	-	-	-	17%	33%	33%	17%
The PHS training program. has leadership support from outside of the organization (e.g. from the PHS Grantee)	-	-	17%	-	-	33%	33%	17%
The PHS training program has strong local public support.	-	-	-	-	-	50%	17%	33%
Funding Stability: Establishing a consistent financial base for the PHS training program.								
The PHS training program exists in a supportive state economic climate.	-	-	-	33%	-	17%	33%	17%
PHS training program/partnership implements policies to help ensure sustained funding.	17%	-	-	17%	-	33%	17%	17%
The PHS training program is financed through a variety of sources	-	-	-	-	17%	33%	17%	33%
The PHS training program has a combination of stable and flexible funding.	-	17%	-	17%	-	33%	-	33%
The PHS training program has sustained longer term funding	17%	-	-	17%	-	33%	-	33%
Partnerships: There is a need for the partnership								
There is a perceived need for the partnership in terms of areas of common interest and complementary capacity.	-	-	-	17%	17%	50%	17%	-
There is a clear goal for the partnership.	-	-	-	17%	17%	50%	17%	-
There is a shared understanding of, and commitment to, this goal among all potential partners.	-	-	-	17%	17%	50%	17%	-
The partners are willing to share some of their ideas, resources, influence and power.	-	-	17%	-	17%	50%	17%	-
The perceived benefits of the partnership outweigh the perceived costs.	-	-	-	-	33%	50%	17%	-

	To little or no extent						To a very great extent	
	1	2	3	4	5	6	7	N/A
Organisational Capacity: Having the internal support and resources needed to effectively manage your PHS training program activities								
The PHS training program is well integrated into the operations of the organisation	-	-	-	-	17%	50%	17%	17%
Organisational systems are in place to support the various PHS training program needs.	-	-	-	-	33%	17%	33%	17%
Leadership effectively articulates the vision of the PHS training program.	-	-	-	-	33%	33%	17%	17%
Leadership efficiently manages staff and other resources.	-	-	17%	-	17%	50%	-	17%
The PHS training program has adequate staff to complete the activities	-	17%	-	-	33%	33%	-	17%
Implementing: Strategic communication with stakeholders and the local population about your program								
Processes that are common across agencies have been standardised (e.g. referral protocols, service standards, data collection and reporting mechanisms).	-	17%	17%	-	17%	33%	17%	-
There is an investment in the partnership of time, personnel, materials or facilities.	-	-	17%	17%	17%	33%	17%	-
Collaborative action by staff and reciprocity between agencies is rewarded by management.	-	-	33%	-	17%	33%	17%	-
The action is adding value (rather than duplicating services) for the community, clients or agencies involved in the partnership	-	-	-	-	33%	50%	17%	-
There is a core group of skilled and committed (in terms of the partnership) staff that has continued over the life of the partnership.	-	-	-	-	50%	33%	17%	-
Program Evaluation: Assessing your program to inform planning and document results								
The program has the capacity for quality program evaluation.	-	-	-	-	33%	50%	-	17%
The program reports short term and intermediate outcomes.	-	-	-	33%	-	50%	-	17%
Evaluation results inform program planning and implementation.	-	-	-	17%	33%	33%	17%	-
Program evaluation results are used to demonstrate successes to funders and other key stakeholders.	-	-	17%	-	17%	50%	-	17%
The program provides strong evidence that the program works.	-	-	17%	-	33%	50%	-	-

	To little or no extent						To a very great extent	
	1	2	3	4	5	6	7	N/A
Program Adaptation: Taking actions that adapt the Program to ensure its ongoing effectiveness								
The program periodically reviews the evidence base.	-	-	-	17%	33%	50%	-	-
The program adapts strategies as needed.	-	-	-	17%	33%	50%	-	-
The program adapts to new approaches.	-	-	-	17%	50%	33%	-	-
There are formal structures for sharing information and resolving demarcation disputes.	-	-	-	17%	17%	50%	-	17%
The program makes decisions about which components are ineffective and should not continue.	-	-	-	33%	33%	33%	-	-
Strategic Planning: Using processes that guide your program's direction, goals, and strategies								
The program plans for future resource needs.	-	17%	-	17%	17%	50%	-	-
The program has a long-term financial plan.	-	17%	17%	-	-	33%	-	33%
The program has a sustainability plan.	-	17%	-	17%	-	33%	-	33%
The program's goals are understood by all stakeholders.	-	17%	-	17%	17%	50%	-	-
The program clearly outlines roles and responsibilities for all stakeholders.	-	17%	-	-	33%	50%	-	-

Table 19: Aggregated scores for each domain, PHS expanded training site partnership and sustainability survey (n=7)

Domain	Score	Maximum
Environmental Support: Having a supportive internal and external climate for the PHS training program	26.3	35
Funding Stability: Establishing a consistent financial base for the PHS training program.	18.5	35
Partnerships: There is a need for the partnership	28.4	35
Organisational Capacity: Having the internal support and resources needed to effectively manage your PHS training program activities	23.2	35
Implementing: Strategic communication with stakeholders and the local population about your program	26.5	35
Program Evaluation: Assessing your program to inform planning and document results	24.0	35
Program Adaptation: Taking actions that adapt the Program to ensure its ongoing effectiveness	25.3	35
Strategic Planning: Using processes that guide your program's direction, goals, and strategies	20.5	35