

Senator Linda Reynolds
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Dear Senator Reynolds

Thank you for the opportunity to make a submission to the Senate Education and Employment Legislation Committee Inquiry into the Migration Amendment (Skilling Australians Fund) Bill 2017 and the Migration (Skilling Australians Fund) Charges Bill 2017

As has been well documented by the Australian Government, the health and community services sector faces a number of immediate and medium term skill shortages¹. Access to skilled migration pathways remains an essential strategy in managing these shortages recognizing that:

- These shortages cannot be met by new Australian graduates where service requirements are for highly skilled and experienced staff.
- Highly skilled and experienced clinicians are needed not only to meet immediate skills shortages but also to support, training and supervise students on clinical placement, graduates and junior staff.
- Demand significantly outstrips domestic supply.
- The age profile of the nursing workforce and an increasing employee preference for part-time work has exacerbated these shortages.

In this context, APHA wishes to raise the following key concerns:

- The proposed training levy adds a significant cost to the employment of clinical staff in the private hospital sector.
- The proposed training levy, with its focus on vocational education and training, will not support training of Australians to meet the future skill shortages of the private hospital sector, and wider health sector.
- Imposition of this levy risks undermining the significant investment currently made by the private hospital sector in training the current and future health workforce.

Training Levy

The Department of Immigration and Border Protection has indicated that the training levy will be determined by “the type of visa sought, the nomination period and the size of the nominating employer’s business (in terms of annual turnover).” This criteria fails to take account of the fact that

- The private hospital sector is already a major provider of training to students, new entrants to the workforce and to existing members of the workforce.
- Use of skilled migration pathways is complementary to investment in training and upskilling. There is no evidence that use of skilled migration has led to an underinvestment by private hospitals in the development of the skills of Australians.

The level at which the levies have been set takes no account of the:

- The net impact of these charges on employees/industries that must of necessity to lodge high volumes of nominations to meet industry skill shortages.
- The high costs of recruitment to rural and remote locations and the need for reliance on migration to fill vacancies in these locations because they are less desirable to Australian candidates.

There is no provision for training levies to be refunded or credited towards subsequent nominations in the event that

- a sponsorship, nomination and/or visa application is refused or withdrawn;
- the employment relationship ceases during the proposed period of employment sponsorship;
- the employee never commences employment; or
- the employee is granted an alternative visa and the TSS visa ceases.

Skilling Australians Fund

The Federal Government has stated that “funding a national training partnership through the sponsorship and nomination framework is an effective mechanism to promote training across a broad range of industries and occupations” and that the fund will “prioritise the funding of apprenticeships and traineeships in occupations that are in high demand and **currently rely on skilled migration**, or have future growth potential, including in regional Australia.”ⁱⁱ However the major skill shortages that need to be addressed by health care sector (the fifth largest industry user of the 457 program) cannot be addressed through apprenticeship and traineeship programs.

As shown in Attachment A, the majority of skill shortages relevant to the hospital sector (both private and public) that addressed through the use of migration visas are for occupations requiring degree level qualifications. Register Nurses, allied health professionals and medical practitioners require degree level qualifications as a minimum. Further professional development and post-graduate education are often required in order to meet the skill requirement that are currently being filled through migration. Occupations that are based on VET qualifications such as enrolled nursing and medical technicians are rarely filled through migration pathways.

The proposed legislation departs from The Department of Immigration and Border Protection’s own response to the independent review into the integrity of the 457 program advised as follows:

6.2 *That any funding raised by way of a training contribution from sponsors of 457 visa holders be invested in:*

- a. training and support initiatives, including job readiness, life skills, and outreach programmes for disengaged groups, particularly youth who have fallen out of the school system*
- b. programmes allowing employers to take on apprentices/trainees from target groups, including Indigenous Australians and those in rural and regional areas*
- c. mentoring programmes and training scholarships aimed at providing upskilling opportunities within the **vocational training and higher education sectors that address critical skills gaps** in the current Australian workforce. **Target sectors include those industries, such as nursing and the IT sector, that rely heavily on 457 workers***
- d. training and support initiatives for sectors of critical national priority. Target sectors include industries experiencing significant increase in labour demands, such as the aged care and disability care sectors.ⁱⁱⁱ*

If this Fund is to support skills relevant to the health sector, it is essential that it support not only vocational training but also the higher education sector.

If this Fund is to reduce Australia's reliance on skilled migration, it will need to target education and labour market programs that address specific skill needs and issues. For example, there are already a large number of graduates exiting Australian universities with degrees in nursing. What is needed is not additional new nursing graduates but programs and initiatives to employ new graduates in numbers that are greater than current graduate requirements (so that they are not lost to the industry and overtime gain experience to meet future skill needs) and encourage experienced registered nurses to acquire the credentials and experience necessary to move into immediate areas of specific shortage.

Labour Market Testing

APHA regards the increased requirements for labour market testing are unreasonable when it has already been well established by government agencies that specific occupations are already in high demand. The Department of Education and Training and Industry already revises the skilled occupations list bi-annually and could easily determine those occupations, such as Perioperative Registered Nurses, and that could be exempted on the basis that they are already known to be in short supply and that there are no additional contingencies required to make the case. In these cases it should be sufficient for the employer to demonstrate, as currently, that they have attempted to fill vacancies from the Australian workforce.

If an employer is required to evidence the need for an overseas trained worker through labour market testing, it should be sufficient for the case to be made at the time of initial hiring. It should not be necessary to remake the case when lodging an application for renewal. Clear guidelines should be provided regarding the type and extent of evidence required so that employers can respond efficiently to this requirement and avoid wastage of valuable resources.

The role of the private hospital sector in training Australia's clinical workforce

The private hospital sector already invests heavily in the training of Australia's clinical workforce. This investment detailed in the attached report *Education and training in the private hospital sector* includes training of students on clinical placement, new graduates, interns, medical registrars, continuing professional development and innovative programs to address specific skill shortages.

Private hospitals have increased their investment in clinical workforce training by nearly 250% in the decade since the last comprehensive survey of the sector was undertaken. In that time, the private hospital sector has increased the value of its gross spend on training from an estimated \$36 million (\$A2004) to up to \$167 million (\$A2015, most recent data available).

These figures demonstrate the private hospital sector's commitment to training Australia's health professionals. It would be disastrous if the increased cost of addressing immediate critical shortages through skilled migration, shortages that cannot be met in any other way, were to draw scarce resources away from investment in the Australian workforce^{iv}.

Recommendations

1. If a training levy is to be charged, businesses already investing in training the Australian workforce should be exempted or have their liability reduced proportionately. Factors that should be taken into account include:
 - Recurrent expenditure on training
 - Recruitment of graduate/internship positions in targeted areas of skill shortage
 - Recruitment of apprenticeship/traineeship positions in targeted areas of skill shortage
2. If a training levy is to be charged it should be payable on an annual or bi-annual basis based on

total TSS visa holders in employment, to reduce the financial impact on each employer sponsor and to also provide greater clarity to the Education and Training sector regarding the availability of funding.

3. If a training levy is to be charged, the funds raised should be targeted to those industries and occupations that currently rely heavily on TTS visas and training programs and initiatives that will directly reduce such reliance in the short and medium term.
4. Sponsors taking over the nomination of an existing TSS visa holder should only be required to pay a pro-rata levy in line with the remaining visa period, or the proposed employment period (whichever is the lesser).
5. The training levy should not be charged retrospectively to any nominations lodged prior to the implementation of the changes, but which have not been finalised at the time of implementation of the legislation. Given the lack of certainty regarding the timing of the implementation of any changes and the ability for the Department of Home Affairs to delay the grant of applications until after the implementation of the changes, we submit any training levy changes passed by Parliament should only apply to those nominations lodged after the implementation of the changes.
6. Additional labour market testing should not be required for occupations where government agencies have already demonstrated a significant skill shortage. In those cases where labour market testing is required, it should only be required at the time of initial hiring.

APHA would welcome the opportunity to discuss further the issues and recommendations raised in this submission.

Yours sincerely

Lucy Cheetham
Director Policy and Research
23 January 2018

ⁱ Health Workforce Australia 2014, "Australia's Future Health Workforce – Nurses – Overview report" (p.vii) <http://www.health.gov.au/internet/main/publishing.nsf/content/australias-future-health-workforce-nurses>
Health Workforce Australia 2014, "Australia's Future Health Workforce – Doctors report" (p.21) <http://www.health.gov.au/internet/main/publishing.nsf/Content/australias-future-health-workforce-doctors>
Health Workforce Australia 2014, "Australia's Future Health Workforce – Nurses – Overview report" (p.8)
Australian Institute of Health and Welfare 2016, "Nursing and midwifery workforce 2015" <https://www.aihw.gov.au/reports/workforce/nursing-and-midwifery-workforce-2015/contents/who-are-nurses-and-midwives>

ⁱⁱ Migration (Skilling Australians Fund) Charges Bill 2017 Explanatory Memorandum (see pages 2 and 8) http://parlinfo.aph.gov.au/parlInfo/download/legislation/ems/r5998_ems_b6e86398-daa4-4fdf-8f26-7d98c65c4dc9/upload_pdf/649701%20240Clean.pdf;fileType=application%2Fpdf and the Migration Amendment (Skilling Australians Fund) Bill 2017 Explanatory Memorandum (p.21) http://parlinfo.aph.gov.au/parlInfo/download/legislation/ems/r5999_ems_347f751d-af6a-460f-a032-6a57f17895b3/upload_pdf/649704%20241Clean.pdf;fileType=application%2Fpdf

ⁱⁱⁱ Government response to the Independent Review into the integrity of the subclass 457 programme, Department of Immigration and Border Protection <https://www.homeaffairs.gov.au/about/reports-publications/reviews-inquiries/independent-review-of-the-457-programme/response-to-integrity>

^{iv} Australian Private Hospitals Association and Catholic Health Australia, Education and training in the private hospital sector, Canberra 2017. http://www.apha.org.au/wp-content/uploads/2017/05/APHA_WorkforceReport_FINAL_May17.pdf

Attachment A: 457 Visas granted to clinical and technical occupations relevant to the hospital sector (public and private) noting that many of these professions are also employed in significant numbers outside the hospital sector.

ANZSCO		Occupation/ Unit group	2016-17		2017-18 to 30 Sept 2017	
			No	%	No	%
Various		Allied Health Professionals relevant to hospitals*	209	7.6%	32	4.1%
253112		Resident Medical Officer	1,222	44.3%	436	56.0%
2532		Anaesthetists	14	0.5%	7	0.9%
2533		Specialist Physicians	49	1.8%	17	2.2%
2534		Psychiatrists	28	1.0%	12	1.5%
2535		Surgeons	28	1.0%	11	1.4%
2539		Other Medical Practitioners	253	9.2%	54	6.9%
2541		Midwives	37	1.3%	11	1.4%
2542		Nurse Educators and Researchers	3	0.1%	3	0.3%
2543		Nurse Managers	14	0.5%	5	0.6%
2544		Registered Nurses (total of the subcategories below)	796	28.9%	173	22.2%
	254411	<i>Nurse Practitioner</i>	5	0.2%	3	0.3%
	254415	<i>Registered Nurse (Critical Care and Emergency)</i>	117	4.2%	32	4.1%
	254416	<i>Registered Nurse (Developmental Disability)</i>	0		0	
	254417	<i>Registered Nurse (Disability and Rehabilitation)</i>	9	0.3%	0	
	254418	<i>Registered Nurse (Medical)</i>	196	7.1%	41	5.3%
	254421	<i>Registered Nurse (Medical Practice)</i>	45	1.6%	6	0.8%
	254422	<i>Registered Nurse (Mental Health)</i>	81	2.9%	14	1.8%
	254423	<i>Registered Nurse (Perioperative)</i>	96	3.5%	26	3.3%
	254424	<i>Registered Nurse (Surgical)</i>	111	4.0%	24	3.1%
	254425	<i>Registered Nurse (Paediatrics)</i>	27	1.0%	8	1.0%
	254499	<i>Registered Nurses n.e.c.</i>	109	4.0%	19	2.4%
4114		Enrolled and Mothercraft Nurses	24	0.9%	3	0.3%
3112		Medical Technicians	82	3.0%	16	2.1%
		TOTAL (for the occupations listed above)	2,759		779	

Notes:

- Allied health professionals relevant to hospitals include ANZSCO codes: 2551 Dietitians, 2512 Medical Imaging Professionals, 2515 Pharmacists, 2524 Occupational Therapists, 2525 Physiotherapists. It should also be noted that there are other allied health professions not included in this table that are employed in the hospital sector but these are in relatively small numbers. Finally the occupations included in this total are frequently employed outside the hospital sector.



Education and training in the private hospital sector

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Executive summary

Private hospitals have increased their investment in clinical workforce training by nearly 250% in the decade since the last comprehensive survey of the sector was undertaken. In that time, the private hospital sector has increased the value of its gross spend on training from an estimated \$36 million (\$A2004) to up to \$167 million (\$A2015). Most of this funding was provided by the private hospital sector itself. This is a significant contribution to the clinical workforce resulting in more and better trained doctors, nurses, midwives and allied health professionals in Australian hospitals.

In 2014–15, it is estimated the private hospital sector delivered up to:

- ▶ \$44.5 million worth of clinical placements, offset in part by fees from universities
- ▶ \$45.0 million in employment and training for medical internships, medical postgraduates and vocational registrars, including support from the Australian Government
- ▶ \$16.5 million in formal training programs for nurse graduates, which translated into more than 1,400 graduate nursing positions.

It is also estimated the sector spent up to:

- ▶ \$38.0 million in training to ensure the safety and quality of clinical services
- ▶ \$18.0 million in training programs that support continuing professional development, organisational change, mission and strategic priorities.

The remaining \$5 million out of the total of \$167 million were costs captured by the survey relating to activities for which estimates could not be extrapolated for the sector as a whole.

These figures demonstrate the private hospital sector's commitment to training Australia's health professionals. This commitment is driven by the need to address workforce shortages, ensure quality of care and support organisational culture and values.

The expansion of clinical training in the private sector over the past decade has occurred despite the private sector experiencing pressure from payers for increased efficiency. There has been no real increase in the average private health insurance benefits paid per episode even though the private hospital sector's casemix has increased in age and complexity. In this context, the increase of clinical training in private hospitals has been the result of deliberate strategic commitments. This growth has also been assisted by changes in government policy supporting additional training opportunities in the private sector.

The private hospital sector contributes both quantitatively and qualitatively by providing training otherwise unavailable or less prevalent in the public hospital sector. Notwithstanding the significant growth in training over the past decade, the private hospital sector could play a greater role.

The private hospital sector's contribution to clinical placements is reflective of its share of the hospital sector workforce, but opportunities remain for further expansion. There is still scope for a wider range of hospitals and day hospitals to be involved in clinical training.

Federal Government funding has enabled 78.5 full time equivalent (FTE) internships for international medical graduates; however, there are still only a handful of postgraduate medical positions available in the private hospital sector. Less than one third of the 932 vocational registrar positions funded by the Federal Government's Specialist Training Program are provided in private hospitals, notwithstanding the breadth of essential clinical learning opportunities available.

This survey finds that, with appropriate long-term funding and support, significant opportunities to develop education and training in the private hospital sector exist, including:

- ▶ expansion of clinical placements for medical, nursing and allied health professionals
- ▶ medical internships for Australian and international medical graduates
- ▶ vocational registrar positions, particularly in specialties of projected shortage
- ▶ vocational registrar positions in specialties where the casemix in the private sector is substantially different to the public sector including psychiatry, anaesthesia, and some surgical specialties
- ▶ graduate positions for registered nurses, enrolled nurses, midwives, and allied health professionals.

The private hospital sector, like the health sector as a whole, has changed over the past decade and will continue to change in response to the shifting needs of the Australian population. The sector is innovative, looking to develop new services in hospital, home and community settings. Training priorities for private hospital providers include not only training related to immediate skill shortages but also training relevant to the growing burden of chronic disease such as mental health nursing, rehabilitation, renal care, diabetes care and palliative care. As new models of care continue to emerge, it will be essential for the private hospital sector to continue to play a prominent role in clinical education and training.

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At the same time, the private hospital sector faces significant challenges as it considers future education and training priorities. These include competing priorities in the allocation of time and resources between service provision and education and training. The need for investment in training of the existing clinical workforce and immediate skill shortages competes with the imperative of forecast demands. Limitations imposed by infrastructure, space and service profile. It is unlikely future expansion of the opportunities listed above will be possible without external financial support and investment in tools to increase collaboration between stakeholders. There will also need to be further consideration given to alleviating barriers to the provision of training, particularly in smaller private hospitals, day hospitals, and hospitals outside of major metropolitan centres.

The Australian Private Hospitals Association (APHA) and Catholic Health Australia (CHA) note many of the issues and recommendations raised in this report echo those already identified by reviews and consultations conducted by government agencies and other stakeholders. APHA and CHA participate in several major consultations and advisory mechanisms including the National Medication Training Advisory Network and the National Nursing and Midwifery Education Advisory Network. It is with awareness of the work already underway in multiple forums at the national and state levels that APHA and CHA are pleased to present this report as a basis for future discussion and continued collaboration between healthcare service providers, education providers and with governments.

Organisations involved in this project

AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION

The APHA is the peak industry body for private hospitals and day hospitals in Australia. It represents both for-profit and not-for-profit providers, accounting for about 70% of private hospital beds and 50% of day hospitals.

CATHOLIC HEALTH AUSTRALIA

CHA represents Australia's largest non-government grouping of hospitals, aged and community care services, providing about 10% of aged care services in Australia, about 25% of private hospital beds and about 5% of public hospital care.

PAXTON PARTNERS

Paxton Partners is a provider of financial, performance improvement, business and management advisory services to the Australian health and human services sector. Paxton Partners were engaged to provide oversight and expertise to the project team. Paxton Partners also provided an independent commentary which has been included in this report at page 51.

Acknowledgement

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The APHA and CHA acknowledge the commitment and contribution of the groups and hospitals that worked hard to provide the data on which this report is based. This project would not have been possible without their support and enthusiasm.

Recommendations

CLINICAL PLACEMENTS

1. All stakeholders¹ work together to:

- ▶ support the growth and increased efficiency of clinical placement programs to include more clinical placements in the private hospital sector
- ▶ increase funding for clinical placements in the private hospital sector
- ▶ provide long-term funding agreements (five years) to enable stronger partnerships and sustained investment
- ▶ standardise datasets used for administrative and monitoring purposes
- ▶ invest in information technology to support program coordination and integration of existing information technology systems
- ▶ standardise documentation requirements for assessments conducted during clinical placements.

MEDICAL TRAINING

2. Governments:

- ▶ increase medical internship funding in the private hospital sector to provide employment opportunities for both Australian and international medical graduates
- ▶ develop minimum five-year funding agreements to enable stronger partnerships between stakeholders in the private sector and sustained investment in training
- ▶ expand and align funding for vocational registrar positions within areas of workforce shortage
- ▶ support expansion of vocational registrar training in light of opportunities only available in the private hospital sector.

NURSING AND MIDWIFERY TRAINING

3. Governments increase funding for supernumerary nursing and midwifery graduate positions at both registered and enrolled levels in the private hospital sector.

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¹ Professional bodies, education providers, public and private sector health service providers, and government agencies.

ALLIED HEALTH TRAINING

- 4. Governments fund opportunities for allied health graduates in the private hospital sector.**

TRAINING THE EXISTING WORKFORCE

- 5. Governments work with all stakeholders to increase access to training materials across the public and private hospital sectors, including e-learning resources developed with government funds to support the National Safety and Quality Health Service Standards.**
- 6. Governments work with all stakeholders to address strategic skill and nurse workforce shortages.**

MAXIMISING CAPACITY TO PROVIDE EDUCATION AND TRAINING

- 7. All stakeholders work together to establish agreed and defined expectations of work-readiness for medical, nursing and allied health graduates seeking entry to internships and graduate positions in either the public or private hospital sector.**
- 8. Governments examine access to and use of simulation facilities across the public and private hospital sectors and across the university and vocational education and training sectors to identify how best to maximise their use.**
- 9. Agencies responsible for accreditation of training programs:**
 - ▶ revise accreditation processes so a wider range of facilities can qualify to be involved in the provision of training programs
 - ▶ streamline processes to minimise costs associated with attaining and maintaining accreditation.

MEASURING THE IMPACT OF TRAINING IN THE PRIVATE HOSPITAL SECTOR

- 10. All stakeholders collaborate to define a common dataset and improve the collection of data on clinical training and education.**

Introduction

Private hospitals² make a significant contribution to training Australia's health professionals. Since the last time a similar survey was undertaken in 2004 (Allen Consulting Group 2005), private hospitals have increased their investment in medical workforce training by nearly 250%. This report outlines the nature of training and education costs incurred by the private hospital sector, along with the return on investment by government. This report also places those achievements in the context of the challenges facing the health sector in addressing current and forecast workforce and skills shortages while at the same time meeting growing demands for health services as efficiently and effectively as possible.

A number of factors have driven expansion of training and education and these will be explored along with opportunities to build and further increase the private sector's role. There are essential differences between the public and private hospital sectors. These create valuable opportunities for education and training where the difficulties presented as a result of these differences can be overcome.

The achievements of the past decade and opportunities for the future need to be understood in the context of rapid change in both the health and education sectors, including the impact of:

- ▶ changes in the university and vocational education and training (VET) sectors in the past 10 years, which have dramatically increased demand for clinical training opportunities
- ▶ government policy changes in relation to provision of clinical placements for university students and early career employment opportunities.

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Additionally, the private hospital sector has undergone and continues to undergo significant changes. Same-day admissions have grown considerably during the past decade. Casemix complexity and the average age of patients on admission have increased. At the same time, the sector is under pressure to achieve increased efficiency while maintaining quality of care.

Australia faces immediate skill shortages in a number of key areas of the clinical workforce and projections of major workforce shortage in nursing. Australia needs to provide clinical experience to record numbers of university and VET students and opportunities to new graduates as they enter the health workforce. Immediate skill shortages include a shortage of experienced theatre, peri-operative and critical care staff. At the same time, the health sector as a whole must address the requirements of a growing burden of chronic disease including skills in mental health, rehabilitation, oncology, renal care, diabetes care and palliative care. As this report will show, the private hospital sector is playing a significant role in meeting all of these challenges.

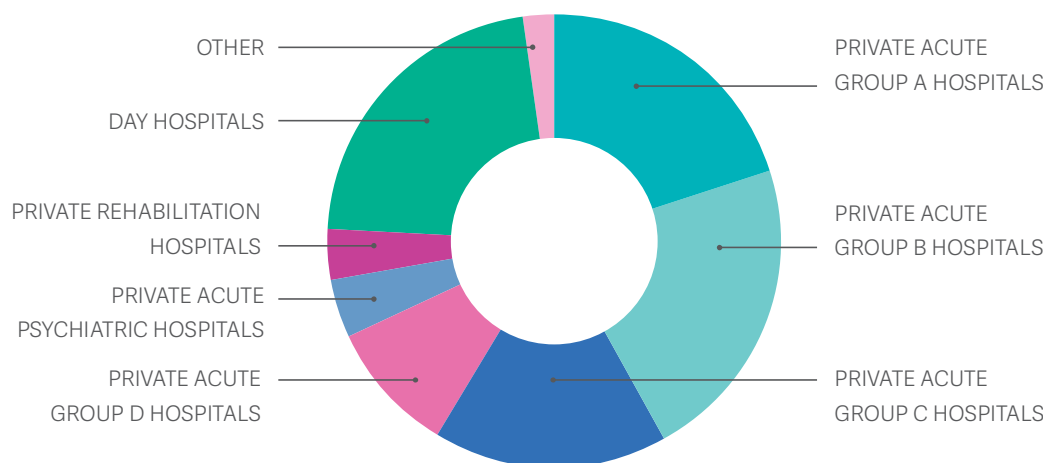
²Throughout this report the term 'private hospitals' is used inclusively to refer to licenced private hospitals and private day hospitals operated within Australia by both for-profit and not-for profit entities. It does not include public hospitals operated under contract by either for-profit or not-for profit entities.

The private hospital sector in Australia

The contribution of the private hospital sector to clinical education and training is important because of its size, and the range of services and distinctive learning opportunities it provides.

The Australian private hospital sector plays a central role in provision of patient services. It accounts for 34% of hospital beds (AIHW 2016b:10) and more than 40% of all hospital separations in Australia (AIHW 2016a:10). The sector is diverse, ranging from large acute hospitals with accident and emergency medicine departments, intensive care units and the full range of medical specialties, through to smaller hospitals focused on a specific range of services and specialties. More than one in five private hospitalisations are treated in a day hospital (AIHW 2016a:10).

Figure 1: Hospitalisations by private hospital peer group, 2012–13



Note: A description of which hospitals fit into each category can be found on page 8.
Source: AIHW 2014.

In addition to the differences of size, structure and ownership between the private and public hospital sectors, there are three key differences that influence the private sector's capacity to provide education and training:

- ▶ the admitted patient profile and treatments provided
- ▶ the staffing profile
- ▶ funding models.

The profile of patients admitted to private hospitals is different to the public hospital sector. Private hospitals are less likely to receive patients with multiple trauma or patients undergoing organ transplants. However, private hospitals still treat seriously ill patients and provide highly complex services. In the following key areas, the private hospital sector provides most of the care:

- ▶ 60% of all hospital separations involving surgery (AIHW 2016a:165, 179)
- ▶ 75% of procedures on the eye and adnexa
- ▶ 66% of procedures on the nose, mouth and pharynx
- ▶ 64% of procedures on the digestive system
- ▶ 59% of procedures on the musculoskeletal system
- ▶ 58% of procedures on the ear and mastoid process (AIHW 2016a:146).

In the following instances the sector provides nearly half of the care:

- ▶ around 40% of all separations associated with chemotherapy (admitted and non-admitted) (AIHW 2016a:113; estimate of non-admitted)
- ▶ 48% of hospital separations associated with mental and behavioural disorders (AIHW 2016a:84–5, 87–8).

Whereas it might once have been presumed students and early career clinicians would receive the most comprehensive clinical experience by working in a large public ‘teaching’ hospital, it is now increasingly recognised that exposure to a range of clinical contexts is essential, including exposure to the private hospital sector.

The public and private hospital sectors also differ in their employment practices and staffing profiles. In the public sector, most medical practitioners are employed (either full-time or part-time) while in the private sector, most medical practitioners practise independently as credentialed medical officers (CMOs). They are credentialed (but not employed) by each hospital to which they have the right to admit patients. The Australian Institute of Health and Welfare (AIHW) estimated that in 2012, the credentialed (but not employed) medical workforce in the private hospital sector equated to 5,653 FTE (AIHW 2014:22); an equivalent estimate has not been published for 2014–15. This differing employment practice is reflected in staffing data.

In 2014–15, the public hospital sector employed 330,400 FTE staff (of which 302,300 were employed at hospital level), whereas the private hospital sector employed more than 64,400 FTE staff (ABS 2016b, AIHW 2016b:61). The clinical staff employment profile of the two sectors is summarised below at Table 1.

Table 1: Staffing profile of the private and public hospital sectors, employed FTE, 2014–15

STAFF	PRIVATE HOSPITAL SECTOR	PUBLIC HOSPITAL SECTOR
Medical	1,215	41,988
Nursing	35,980	140,213
Diagnostic and allied health	3,771	46,306
Clinical support	4,729	Not available
Other, non-clinical staff	18,732	102,134
Total	64,428	330,433

Source: ABS 2016b; AIHW 2016b:61.

The profile of the private hospital workforce means it is not always possible to replicate the same models of supervision found in a major public hospital. At the same time, the sector offers exposure to alternative models of care.

The private hospital sector is reliant on various fee-for-service models to fund clinical services. None of these funding models include provision of funding for clinical education and training. While there has been some capacity for vocational registrars to bill the Medicare Benefits Schedule for the services they provide, this has been limited and insufficient to fund these positions and the associated supervision and training costs.

With limited exceptions, private hospitals have only recently had access to government funding to support education and training activities or the employment of interns, vocational registrars or graduates in any of the clinical professions. By contrast, funding of the public hospital sector has always included recognition of the public sector's role in the provision of education and training. These limitations have significantly shaped the way in which education and training has grown in the private sector.

The changing nature of clinical training

In the past decade, the landscape of clinical education and training has changed substantially. Since 2004, there has been a dramatic increase in the number of students undertaking courses in medicine, nursing and allied health.

Between 2004 and 2014 there was a:

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- ▶ doubling of university enrolments in health-related courses, the majority of which train students to enter clinical professions (Department of Education and Training (DET) 2005a, DET 2015b)
- ▶ doubling of university enrolments in nursing programs³ (DET 2005b; DET 2015c)
- ▶ 70% increase in university enrolments in medicine (Department of Health 2006; Department of Health 2015b:19).

Additionally, a demand-driven market for nursing programs from 2009 (Mason Review 2013:261) saw domestic commencements (first-year students) in nursing increase by nearly 50% (DET 2009; DET 2015c).

An uncapped market for international university students saw international enrolments hit 6,867 nursing and 3,456 medical students in 2014 (DET 2015c).

Vocational education and training enrolments in enrolled nursing programs increased from 13,815 in 2005 to a peak of 23,225 in 2011 before falling slightly in 2012, the most recent year for which data is available (unpublished National Centre for Vocational Education Research data cited in AIHW 2008; HWA 2014).

³ The figures reference nursing- and medicine-related programs qualifying students for initial registration in nursing and provisional registration in medicine.

Table 2: Higher education student data, enrolments and commencements, 2004, 2008 and 2014

	2004	2008	2014	PERCENTAGE INCREASE (%)
University enrolments, health-related courses	102,978		209,747	103.7
University enrolments, nursing programs	25,881		53,542	106.9
University enrolments, medicine	9,935		16,837	69.5
University commencements, nursing		13,598	20,266	49.0

Note: These figures include domestic and international students.

All figures are from the Australian Department of Education and Training, apart from enrolments in medicine, which is from the Department of Health.

Sources: DET 2005a, DET 2005b; DET 2015b; DET 2015c, Department of Health 2015b:216.

These increases have driven growing demand for clinical placements. Higher levels of enrolment have also increased graduations from university courses in nursing and medicine. Between 2004 and 2014 the number of:

- graduates qualifying for initial registration as nurses has nearly doubled
- medical graduates qualifying for provisional registration has more than doubled (DET 2015a) (Table 3).

Table 3: Higher education student data, graduates, 2004 and 2014

	2004	2014	PERCENTAGE INCREASE (%)
Graduates, initial registration in nursing	5,976	11,640	94.8
Graduates, provisional medical registration	1,508	3,595	138.4

Source: DET 2015a.

In 2014, 3,211 Australian medical graduates and 76 international onshore graduates were placed in a postgraduate year (PGY1) supervised position (Department of Health 2015b:52, 55).

This increase in clinical students has been greater than the expansion of the Australian hospital sector, which, in terms of patient care days, has expanded 20% over the same period (AIHW 2016: 23, AIHW 2006:12). This presents the Australian health sector with the challenge of providing enough clinical placements for students and initial employment for graduates in their chosen professions. Although the range of opportunities has broadened to some extent, hospitals remain the primary context for medical graduates to complete full registration requirements and for nursing graduates and many allied health graduates to embark on their professional careers.

In response, some governments have intervened to create entry-level employment for these graduates. State governments have thus far fulfilled their commitment to provide internships for Australian medical graduates. Some state governments have funded additional positions for graduate nurses. The Federal Government has funded positions specifically for international medical graduates.

Some government responses to the growing demand for clinical education and training have enabled the private hospital sector to play a greater role. These initiatives include:

- ▶ increased Federal funding for specialist medical training in expanded settings, including specific initiatives supporting a total of 932 posts (Department of Health 2015a)
- ▶ Federal funding for up to 100 internship positions each year for international graduates from Australian medical schools⁴
- ▶ increased Federal funding and increased flexibility in the allocation of funding for clinical placements through universities, some of which has flowed through to expand provision of placements in private hospitals
- ▶ initiatives in some jurisdictions to actively encourage training networks involving both public and private hospital sector participants.

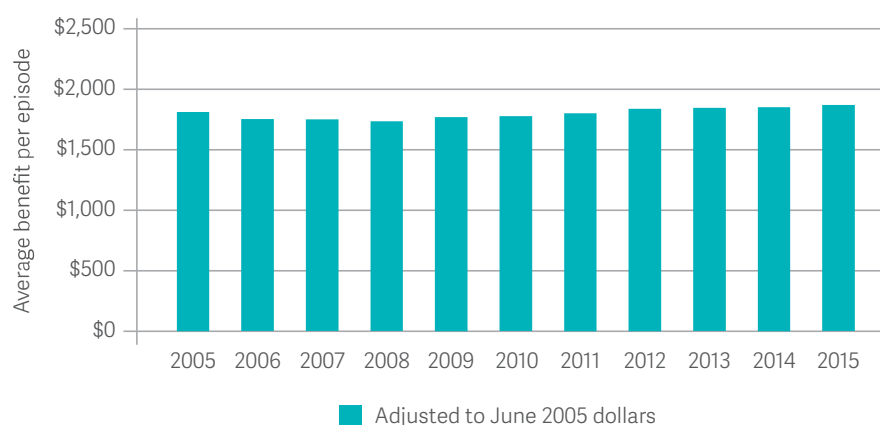
The changing nature of the private hospital sector

In the ten years to 2014-15, the proportion of hospitalisations (40%) treated in the private sector has remained constant. However, the service context, efficiencies demanded by payers, and the profile of patients cared for in the private sector has changed considerably. There is every reason to expect these trends will continue and intensify in the future.

During this period, the private hospital sector expanded, with a 20% increase in the number of private hospital beds and an increase of more than 60% in the number of hospitalisations. The number of day hospitals surged nearly 40%. Day hospitals now account for one in five private hospital separations (ABS 2006; ABS 2016b; AIHW 2016a).

Additionally, individual consumers, health insurers and government agencies have sought to maximise value and contain expenditure, causing private hospitals to seek greater efficiencies in service delivery. When adjusted for inflation, the average private health insurance benefit per episode paid for hospital services (exclusive of the benefits paid to medical specialists and costs of prostheses) increased by only 3% between 2004-05 and 2014-15 (ABS 2016a; APRA 2016a).

Figure 2: Average private health insurance benefits paid out for hospital care, per episode, year ending 30 June

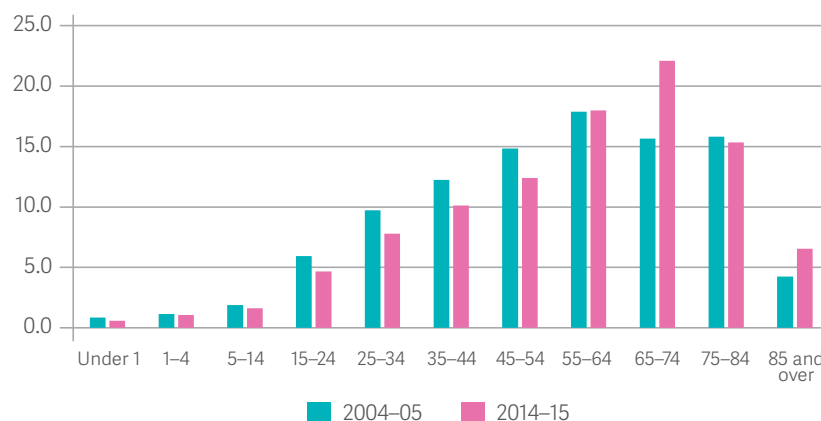


Source: APRA 2016a; ABS 2016a.

⁴ This began with the Additional Medical Internships 2013 initiative; subsequently renamed the Commonwealth Medical Interns Initiative.

Over the same period, the cost and complexity of hospital care has risen. The profile of patients treated by private hospitals has aged, resulting in an increased incidence of comorbidity.

Figure 3: Age distribution of patients in private hospitals, 2004–05 and 2014–15



Source: AIHW 2016a.

The average cost weight – a guide to expected resource use per separation and an indicator of casemix complexity – increased from 0.77 in 2010–11 to 0.81 in 2014–15, an average annual increase of about 1.5% (AIHW 2016a:201).

The private hospital sector has changed significantly in the past decade and will continue to change and innovate in response to the changing healthcare needs of the Australian population. Private hospitals are also seeking to develop new models of care in response to the needs of the ageing population and the increasing incidence of chronic disease. For example, private psychiatric hospitals provide in-patient services as well as day programs and outreach support. Rehabilitation hospitals provide in-patient services and day programs not only for people recovering from surgery but also for the full range of chronic conditions for which rehabilitation and reconditioning is recommended. The private hospital sector also plays an important role in palliative care.

Notwithstanding this challenging operating environment, the private hospital sector has significantly increased its role in education and training over the past decade and remains actively engaged and interested in working with other stakeholders to meet the healthcare needs of Australians.

Survey methodology

This report presents results from the APHA/CHA education and training survey 2014–15, which ran from September to December 2015, capturing data for the financial year.

Participants in this survey self-selected, first through membership of either APHA or CHA and second through committing resources to data collection. APHA and CHA received some form of data response from 205 hospitals. Full survey responses were received from 97 private hospitals and two day hospitals. A further 64 hospitals and 42 day hospitals provided a limited subset of information. These responses represent 60% of private hospitals and 18% of day hospitals in Australia. A profile of respondents according to private sector peer groups devised by the AIHW is shown at Table 4.

The AIHW peer groups for private hospitals were used as an analytical framework throughout this report to provide an independently constructed means of aggregating data for the private sector. However, it should be noted that this framework was designed specifically for the private hospital sector and does not provide a basis for comparison between private and public hospitals.

Data presented in this report are from survey respondents, unless stated otherwise. Where survey results were used to estimate the quantum of training and associated costs incurred by the private hospital sector as a whole, the estimated cost range has been rounded to the nearest \$500,000. As a result, the estimate of total activity is different from the sum of component ranges due to rounding. For further detail on the methodology of the survey, please refer to Appendix A.

Table 4: Profile of respondents and the private hospital sector by AIHW peer group

AIHW PEER GROUP	RESPONDENTS	PRIVATE HOSPITALS IDENTIFIED BY AIHW
Private acute group A hospitals Hospitals that have a 24-hour emergency department and an intensive care unit, and provide a number of other specialised services such as coronary care, special care nursery, cardiac surgery and neurosurgery.	20	22
Private acute group B hospitals Hospitals that do not have a 24-hour emergency department, but do have an intensive care unit and a number of other specialised services including coronary care, special care nursery, cardiac surgery and neurosurgery.	25	36
Private acute group C hospitals Hospitals that do not provide emergency department services or have an intensive care unit, but do provide specialised services in a range of clinical specialties.	35	49
Private acute group D hospitals Hospitals that do not meet the criteria for Groups A, B or C but have more than 200 separations per year.	32	71
Private acute psychiatric hospitals	22	28
Private rehabilitation hospitals	14	23
Day hospitals	44	247
Other hospitals Any hospital not included in the above categories, including unpeered hospitals.	13	41
Total	205	517

Note: These peer groups are not intended to support comparison between the public and private hospital sectors (AIHW 2015).

Source: APHA/CHA education and training survey 2014–15; AIHW 2015.

Summary

The private hospital sector is diverse. It provides a range of opportunities for training and clinical experience to extend and complement those provided in the public hospital sector.

Even if it were possible to sufficiently expand traditional public hospital sector opportunities for clinical placements and graduate/internship programs to meet growing demand, it is beyond the public hospital sector's capacity to provide the breadth of clinical experience required to meet the needs of the future Australian health workforce.

It is now more important than ever to increase training and education opportunities in the private hospital sector in response to skill shortages relevant to acute in-patient services and to new innovative services relevant to the growing burden of chronic disease.

The past decade has seen significant investment by governments in increasing training opportunities in the private hospital sector and in encouraging networking and collaboration between the public and private hospital sectors. It is unlikely further expansion will be possible without continued government financial support, innovation and closer collaboration between all stakeholders.

Clinical placements

The private hospital sector has a long tradition of clinical training, particularly for nurses and midwives (Mason Review 2013:85). It is estimated in 2014–15, private hospitals provided:

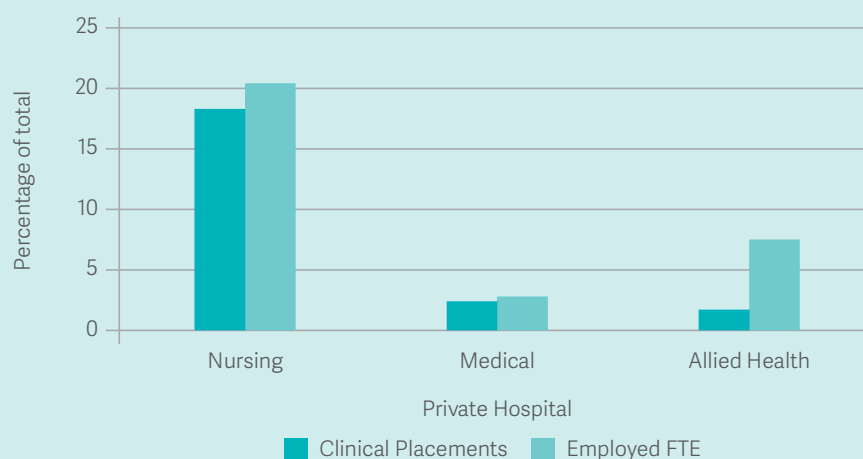
- ▶ 40,400 days of clinical placement for medical students
- ▶ 304,800 days of clinical placement of nursing and midwifery students
- ▶ 28,900 days of clinical placement for allied health students.

Students undertaking university and vocational education and training programs to qualify for entry into clinical professions require exposure to real-world clinical situations to put their theoretical knowledge into practice. They also need to practise and demonstrate clinical skills and gain exposure to the occupations and work environments they are preparing to enter. For some professions, professional bodies define requirements for clinical placements.

The total actual cost reported by survey respondents (n=79) for clinical placements was \$17.2 million for 2014–15. Although variability in agreements between hospitals and universities makes it difficult to generalise, the total cost of clinical placements for the private hospital sector in 2014–15 was estimated to be between \$39.5 and \$44.5 million.⁵

These numbers are small relative to the total demand for clinical placements, yet are significant relative to the staffing profile of the private hospital sector shown in the chart below.

Figure 4: Proportion of clinical placements provided and staffing profile of the private hospital sector compared to elsewhere, 2014–15



Source: APHA/CHA education and training survey 2014–15.

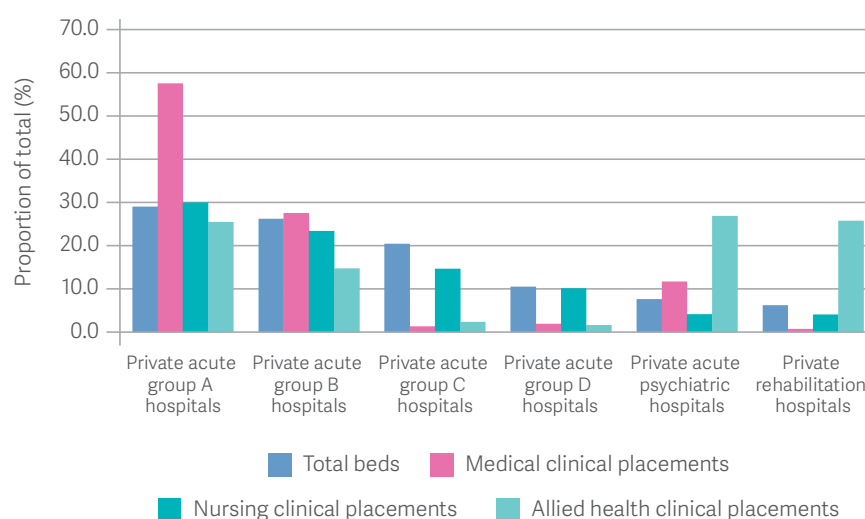
⁵ This estimated cost excludes:

- ▶ the cost of medical supervision (CMOs bear this cost themselves)
- ▶ costs associated with equipment and infrastructure.

The relatively low number of placements for medical and allied health students can be explained in part by the employment profile of clinical professions in the private hospital sector. The private hospital sector directly employs few medical and allied health professionals. Therefore, fewer staff in these groups are available to undertake supervision, mentoring and assessment. It is not unusual for allied health professionals working in the private hospital sector to be employed by third parties who provide allied health services to the private hospital on a contractual basis. One respondent to the survey commented that it was a challenge to provide clinical placements for professions employed in low numbers within the facility. Consequently, it was not surprising only 57 survey respondents provided training for allied health professionals.

The provision of clinical placements is not evenly spread across the private hospital sector. The following chart shows the distribution of clinical placement opportunities across private hospital peer groups relative to the distribution of hospital beds.

Figure 5: Distribution of beds and estimated total clinical placement days, by selected private hospital peer groups



Source: APHA/CHA education and training survey 2014–15.

The distribution of clinical placements for medical students is the most concentrated, found predominantly in larger private acute group A and B hospitals. Private acute psychiatric hospitals also make a significant contribution. Clinical placements for nursing students are spread more widely, although it is estimated 30% of clinical placement days occur in private acute group A hospitals. While provision for clinical placements in allied health is small, these opportunities are mainly found across private acute group A and B hospitals, private acute psychiatric hospitals and private rehabilitation hospitals. There would appear to be limited opportunities in the day hospital sector for clinical placements, with a few notable exceptions.

Notwithstanding these limitations, the private hospital sector is interested in exploring the scope for expansion. The challenges that will need to be addressed are discussed over the page.

Training in a day hospital

The Skin and Cancer Foundation Australia estimates four out of five New South Wales dermatologists who have graduated in the past 20 years will have spent at least one year of their training at either its Westmead or Darlinghurst centres.

The Foundation provides training of over \$1 million annually across all of its training activities, including dermatology registrars, dermatologists, medical students, general practitioners, nurses and other staff.

A registered training organisation, the Foundation offers training to medical students, medical vocational registrars and nurses demonstrating how comprehensive training programs can be integrated into a day hospital environment.

Challenges in providing clinical placements

Managing relationships with universities and vocational education and training providers is the biggest barrier to expansion in clinical placements. Issues for private hospitals include lack of support from training organisations and difficulty in recruiting staff to undertake supervision, mentoring and assessment in addition to day-to-day clinical responsibilities.

“Inflexibility of training organisations... Not enough funding or support... Lack of systems report to accurately capture all that we do in relation to education and training... Information technology infrastructure and system support... Extremely limited learning management systems that also require high levels of administration support.”

[PRIVATE ACUTE GROUP A HOSPITAL – METROPOLITAN]

Most hospitals manage relationships with numerous education providers in both the university and VET sectors. Overseeing multiple relationships and diverse clinical placement, supervision, funding and reporting requirements add to the cost of providing clinical placements in the private hospital sector.

A medical surgical hospital working with multiple educational organisations described the following challenges:

“All universities and technical and further education (TAFE) have different versions of similar assessment tools and/or requirements. This does impact on facilitator time for completion of these tools. Time also includes ongoing training in facility requirements for student placement for all facilitators and notification to all clinical staff that students are working with. Each facility also has different methods of performance review in regards to issues or concerns, again increasing time required for awareness and ongoing training support.”

[PRIVATE ACUTE GROUP A HOSPITAL – MAJOR CITY]

Private hospitals must understand and keep up with diverse assessment requirements. This issue is particularly pronounced in relation to medical placements. In nursing, the Australian Nursing and Midwifery Accreditation Council framework has reduced, but not eliminated, diversity. The Nursing Competency Assessment Schedule is used widely, but individual institutions sometimes add specific requirements. Other universities use the Professional Experience Placement Record approach. This issue impacts on the training of supervisors and time devoted to assessment processes.

Some corporate groups of hospitals have negotiated minimisation of these problems. Others limit the number of education providers they work with. However, diversity and complexity of these arrangements may limit capacity for further expansion of training in the private hospital sector.

The survey results suggest introducing standardised clinical assessment tools could reduce clinical placement costs in private hospitals and potentially expand capacity. Recent research also indicates this would improve the “provision of consistent, reliable and objective assessment of student skills and competency” (Morrow et al. 2016).

Another cause of variation in the relationship between universities, VET providers and hospitals is the extent to which university/VET staff are involved in supervision and assessment.

“The supervision requirements are different for all universities that our hospital has relationships with... the cost impact is multi-level [and] includes: salary and wages the increased time the facilitators of the students on clinical placement are required to complete... the preceptors... universities expectations of the hospital providing placements.”

[PRIVATE ACUTE GROUP B HOSPITAL – MAJOR CITY]

Although remuneration was sometimes provided for assessment, it was not always commensurate with actual cost.

Another barrier identified was the cost and complexity of coordinating arrangements with multiple education providers. One independent private psychiatric hospital described the impact of working with just three universities:

“The hospital uses three different universities to provide nursing students and all have differing requirements and all changes impact on cost since there is no uniformity to leverage off. One only sends the students for a six-day mental health placement. One sends year two students for two weeks and year three students for three weeks. One sends all students irrespective of year for three weeks. All have differing assessment tools.”

[PRIVATE ACUTE PSYCHIATRIC HOSPITAL – METROPOLITAN]

Some hospitals have succeeded in addressing some of these problems by developing longstanding relationships with particular universities.

Clinical school in Ballarat

The Australian Catholic University/St John of God Ballarat Hospital clinical school provides a regionally based nursing program. Developed in 2012, the program recruits 12 new nursing students into the clinical school each year. There are 34 students at various stages of study with plans for further growth. All clinical placements are completed at St John of God Ballarat and St John of God Pinelodge Clinic (psychiatric).

St John of God reports a number of benefits to the hospital and the students including: continuity of practice, good relationships between educators, students and caregivers, and improved workforce planning.

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Meeting demand for clinical placements

Increased enrolments at both undergraduate and postgraduate level have driven demand for clinical placements. Access to clinical placements for students is essential to assess clinical competence. “Clinical competence is performance based. Assessors must therefore carry out the assessment in the context of the nurse and/ or midwife interaction with the person receiving care.” (NMBA 2016: Principle 2)

The rapid growth in demand over the past decade, increased reliance on clinicians to undertake assessment of students and the complexity and diversity of assessment requirements have all given rise to an increased requirement from hospitals, both public and private, for these activities to be funded. Some stakeholders have expressed concern government funding to universities for clinical placements has given rise to hospitals (in both the public and private sectors) charging and increasing fees for provision of placements, which were previously provided on a pro bono basis (Buchanan et al. 2014).

It must also be noted student numbers have risen far more quickly than the size of the workforce available within the private hospital sector to provide appropriate supervision and support. Private hospitals have needed to recruit clinical educators and administrative staff to manage clinical placements programs as they grow in size and complexity. Many programs are both larger and more sophisticated than those provided on a pro bono basis in the past.

The cost of providing clinical placements depends on a number of factors. Survey results indicated there was a wide variance in cost per day for clinical placements. This variability is likely a reflection of the diversity in arrangements between universities, VET providers and hospitals. Although the survey did not investigate models of supervision, it is understood there are range of models in use, including:

- ▶ facilitation of a small group of students either within or across multiple sites
- ▶ 'preceptorship'; a one-on-one partnership for the duration of the placement
- ▶ hybrid models such as the integrated professional practice models and the cluster model where students work with clinical staff and with 'facilitators' or 'clinical associate' staff who provide coordination and support to clinical staff.⁶

While the survey identified cost pressures, it also identified potential scope to reduce the costs and increase capacity to provide placements in the private hospital sector by improving and streamlining administrative supports and redesigning processes to take account of the needs of all parties.

"National information technology support... A national assessment tool... To increase capacity more appropriate use of the 21 shifts that are available for clinical placement... Appropriate supervision models... Infrastructure support."

[PRIVATE ACUTE GROUP B HOSPITAL – MAJOR CITY]

"Better collaboration between hospitals and training organisations. Many base their model on what suits the organisation and their students, not what suits the hospitals..."

[PRIVATE ACUTE GROUP A HOSPITAL – METROPOLITAN]

These challenges aside, there are a significant number of private hospitals interested in expanding clinical placements if an appropriate level of resourcing and support is provided.

"We are currently taking medical and nursing students and would like to increase this to include allied health."

[PRIVATE ACUTE PSYCHIATRIC HOSPITAL – MAJOR CITY]

⁶ An example of this can be found in the guide for clinical facilitators and preceptors, Griffith University School of Nursing and Midwifery. Accessed on 7 July 2016. Available online at: https://www.griffith.edu.au/_data/assets/pdf_file/0011/685982/BN-Guide-for-Clinical-Facilitators-Final_2016V1.2.pdf.

In light of these cost pressures and the need to continue to expand placement opportunities, it is important respective roles of each stakeholder (hospitals, governments and education providers) be clearly understood and well-defined to maximise efficiency and ensure return on investment in the expansion of clinical training opportunities.

Summary

Private hospitals make a significant contribution to provision of clinical placements, particularly in nursing and midwifery.

The number and distribution of clinical placements suggest there may be scope for further expansion, either by increasing the number of clinical placements at hospitals already participating, or by increasing the number of hospitals and day hospitals involved.

If clinical placements are to expand in the private sector, government, education providers and private hospitals will need to work together to:

- ▶ reduce the cost of managing multiple relationships
- ▶ invest in information technology to support program coordination
- ▶ standardise documentation requirements for assessments conducted during clinical placements.

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Recommendation 1

All stakeholders – professional bodies, education providers, public and private sector health service providers, and government agencies – work together to:

- ▶ support the growth and increased efficiency of clinical placement programs to include more clinical placements in the private hospital sector
- ▶ increase funding for clinical placements in the private hospital sector
- ▶ provide long-term funding agreements (five years) to enable stronger partnerships and sustained investment
- ▶ standardise datasets used for administrative and monitoring purposes
- ▶ invest in information technology to support program coordination and integration of existing information technology systems
- ▶ standardise documentation requirements for assessments conducted during clinical placements.

Medical training

Since 2004, private hospitals have expanded their role in medical training, broadening the range of training and clinical experience available to junior doctors. This increase developed from the need to ensure a future workforce and from recognition within the private sector of the role of training in organisational culture. This increase in medical training in the private hospital sector has been strongly supported by government incentives and funding.

Medical students graduating from recognised programs qualify for provisional registration upon graduation. They are then able to seek employment as medical interns and commence several years of further training while working under supervision at hospitals accredited to provide medical internships.

The first internship year is known as postgraduate year 1 (PGY1). Following this year, junior doctors can apply to enter training programs to become either general practitioners or medical specialists, although it is not uncommon for junior doctors to continue employment with hospitals for a further year or more while they continue to gain clinical experience in a stage termed 'PGY2 plus'.

Australian medical students must also complete several years of practical education after graduation in order to meet the clinical training requirements of their specialty. Junior doctors accepted by a medical specialist college are employed as vocational registrars in posts accredited by the colleges as meeting their requirements by providing appropriate levels of clinical experience, supervision and support. These training pathways are summarised below:

PGY1 internship:	PGY2 plus:	Medical specialist training:
a structured year of employment and training within a hospital environment	one or more years of further employment as a junior doctor within a hospital	three or more years of being employed as a junior doctor as a medical vocational registrar. In some specialties, this involves a two-stage program of 'basic' and 'advanced' training
Year 1	Years 2–3	Years 3 and onwards

Because of the nature of private hospital work, it exposes students and junior doctors to models of care and a patient casemix different from that encountered in major acute public hospitals. Private hospitals therefore play a vital role in equipping medical students and junior doctors with a well-rounded base from which to enter their profession.

Table 5 provides the estimated size and scope of private hospitals' involvement in the provision of internship and postgraduate year positions.

Table 5: Medical training positions, FTE and number of hospitals involved

LEVEL	FTE	NUMBER OF HOSPITALS
PGY1 internship	78.5 ^(a)	19
PGY2 plus	96.6 ^(b)	7
Vocational registrar	282.0 ^(b)	> 66

(a) Commonwealth medical internships program

(b) Estimate based on responses from the APHA/CHA education and training survey 2014–15.

Source: APHA/CHA education and training survey 2014–15; Commonwealth of Australia 2015:145.

Medical internships

Relative to the number of medical graduates seeking internships per year, the contribution of the private sector was modest in 2014–15; less than 2%. These internships were predominantly confined to international graduates and a small number of private hospitals. This is reflective of accreditation requirements, historical arrangements (i.e. training programs at former repatriation hospitals)⁷ (Mason Review 2013:90) and the limited scope of new national funding initiatives, but it is also indicative of the private hospital sector's capacity to provide training traditionally provided only in the public hospital sector.

In 2013, the Federal Government created the Investing in Medical Internships program for international students graduating onshore from Australian medical schools. This program committed \$40 million (GST exclusive) over four years from 2013–14, for up to 100 internships a year (Department of Health 2014). In 2013, the program resulted in 22 interns being employed in mainly private hospitals in Western Australia, Queensland, the Australian Capital Territory, the Northern Territory and New South Wales (Department of Health 2013:177).

As the program developed, 76 international onshore medical graduates were placed in Federally-funded positions in 2014: 61 in Queensland and 15 in Western Australia (Department of Health 2015b:52). In 2015, 84 international onshore medical graduates were placed in Federally-funded positions (Commonwealth of Australia 2015:145).

Based on survey results and government reports, it is estimated 19 private hospitals provided medical internship training in 2014–15. An estimated seven hospitals provided PGY2 plus positions. Most of these positions were in hospitals with the following characteristics:

- ▶ located in Queensland, Western Australia, New South Wales and Victoria
- ▶ private acute group A and B hospitals. There were also isolated instances of involvement across private acute groups C and D and private acute psychiatric hospitals
- ▶ ability to meet accreditation requirements independently or through partnerships with other hospitals.⁸

⁷ Historically, the Department of Veterans Affairs funded clinical training for junior medical officers. These funding arrangements continued when Ramsay Health Care acquired Greenslopes and Hollywood Private Hospitals.

⁸ Hospitals funded to deliver internships must meet the formal accreditation requirements of the Medical Board of Australia or partner with other hospitals to enable them to do so (Department of Health 2014:10).

The capacity of hospitals to take on interns was also linked to their ability to provide positions for PGY2 (and above) and vocational registrars, because the ongoing presence of more experienced junior doctors is intrinsic to the provision of appropriate support to, and supervision of, medical interns.

Only hospitals in the private acute group A hospitals peer group are able to provide the full range of experiences required as part of a medical internship program. However, hospitals in other peer groups provide valuable experiences and contribute to the expansion of training opportunities when they are part of networks of hospitals able to provide a clinical rotation.

Key constraints to further expansion are:

- ▶ lack of funding for positions to accommodate both domestic and international graduates
- ▶ lack of support for private sector settings at jurisdictional level in some jurisdictions
- ▶ limited capacity to provide medical supervision within a fee-for-service environment without additional resourcing
- ▶ the inability of some hospitals to meet accreditation requirements.

These difficulties notwithstanding, a significant number of survey respondents wished to expand internship opportunities. The 2015 Independent Review of Medical Intern Training noted this willingness: "Our view is that in addition to any benefit to capacity, a primary reason to pursue intern placements in [private] settings is the educational value of access to the range of modern health care settings. We recognise the major barrier to this would appear to be current funding arrangements." (Wilson & Feyer 2015:29)

The review recommended expansion of training settings be further supported through:

- a) Jurisdictions and the private and not for profit sector identifying and, where feasible and affordable, implementing opportunities to expand suitable placements in private, not for profit and community settings, within one to two years.
- b) The Commonwealth Government providing targeted access to Medicare billing arrangements for PGY2 doctors placed in general practice settings, within one to two years.
- c) Analysis of interns' service contribution in different settings to inform discussion on their role and help define benchmarks for private sector contribution to their training, within one to two years. (Wilson & Feyer 2015:8, 33)

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Summary

The provision of internship opportunities appears to be directly proportional to the number of positions funded. If the private hospital sector is to play a greater role in the provision of internships, there will need to be cooperation of all stakeholders including implementation of the recommendations of the Independent Review of Medical Intern Training and provision of additional funding for medical internships.

Specialist vocational registrars

Specialist vocational registrar positions have expanded significantly in the private sector over the past 10 years and are estimated at more than 280 FTE in 2014–15. In many medical specialties, the opportunity to work in the private sector provides a range of experiences different to public acute hospitals and crucial to providing trainees with a comprehensive grounding in their chosen specialty. The cost of this training to the private hospital sector in 2014–15 was estimated at up to \$27.5 million,⁹ including the salary costs of vocational registrar positions.

Junior doctors seeking to qualify as medical specialists must win a position in the training program of the relevant medical college and secure employment as a vocational registrar at a hospital holding accreditation with their specialist college. It typically takes six years or more for registrars to complete their training. During this time, they are employed to work under the supervision of qualified specialists.

The expansion of vocational registrar training in the private sector has been supported over several years by funding from the Federal Government.¹⁰ However, despite this investment, the number of training opportunities available remains well below the number of posts accredited and the potential capacity of the private sector to play a role in the training of medical specialists.

Of the 932 positions funded by the Federal Government in 2014–15, less than a third were in private hospitals, despite, as shown in Table 6, the highly significant role played by the sector in a number of key areas of projected shortage including:

- obstetrics and gynaecology
- ophthalmology
- psychiatry
- diagnostic radiology
- radiation oncology (HWA 2012:9).

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Table 6: Service delivery of private hospitals, by priority area

MAJOR DIAGNOSTIC CATEGORY/ PROCEDURE	SPECIALTY	PRIVATE HOSPITAL SEPARATIONS 2014–15	
		Number	Proportion of total
Pregnancy, childbirth and puerperium	Obstetrics	140,388	27%
Diseases and disorders of the female reproductive system	Gynaecology	182,073	60%
Diseases and disorders of the eye	Ophthalmology	285,753	71%
Mental diseases and disorders	Psychiatry	144,793	51%
In-hospital radiation oncology procedures	Radiation oncology	4,132	24%

Source: AIHW 2016a:110, 146.

The involvement of the private hospital sector in vocational registrar training is diverse, indicating the breadth of opportunities available. Table 7 shows private hospital placements were found in 16 of the 23 specialties reported by the Medical Training Review Panel (MTRP); a further four had an unknown number of placements.

⁹ Costs reported through the survey for vocational registrar training (n=25) totalled \$15.9 million. Based on this result, the estimated cost for the private hospital sector as a whole was between \$25.5 and \$27.5 million, including salary costs for registrars and medical supervision but excluding equipment and infrastructure and costs borne by CMOs.

¹⁰ The Federal Government has funded vocational training through the Specialist Training Program (STP) and the Emergency Medicine Program (EMP).

Table 7: Vocational registrar positions, by specialty

	ESTIMATED PRIVATE HOSPITAL PROVISION	MTRP DATA		SPECIALIST TRAINING PROGRAM	
MEDICAL SPECIALTY	FTE	PROPORTION(%)	TRAINEES	PROPORTION(%)	POSTS
Physicians					391
Addiction medicine	1.0	0.4	22	0.1	
Adult medicine	53.0	18.8	4,398	23.0	
Occupational and environmental medicine	0.0	0.0	92	0.5	
Paediatrics	5.0	1.8	1,480	7.7	
Palliative medicine	2.0	0.7	28	0.1	
Rehabilitation medicine	17.3	6.1	202	1.1	
Public health medicine	0.0	0.0	81	0.4	
Sexual health medicine	0.0	0.0	13	0.1	
Anaesthesia	11.5	4.1	1,207	6.3	42
Anaesthesia – pain medicine	1.0	0.4	66	0.3	
Dermatology	12.3	4.4	99	0.5	30
Emergency medicine	18.0	6.4	2,111	11.0	2
General practice	0.0	0.0	4,486	23.4	
Intensive care	18.0	6.4	544	2.8	17
Medical administration	3.0	1.1	115	0.6	24
Obstetrics and gynaecology	4.0	1.4	541	2.8	32
Ophthalmology	1.8	0.6	144	0.8	12
Pathology	Unknown	Unknown	307	1.6	87
Pathology and Royal Australasian College of Physicians (jointly)	Unknown	Unknown	236	1.2	
Psychiatry	33.4	11.8	1,286	6.7	178
Radiology					40
Radiation oncology	Unknown	Unknown	117	0.6	40
Radiodiagnosis	5.0	1.8	410	2.1	
Sport and exercise medicine	0.0	0.0	41	0.2	4
Surgery	38.0	13.5	1,094	5.7	73
Oral and maxillofacial surgery	Unknown	Unknown	38	0.2	
Unknown (estimate)	57.7	20.5			
Total (estimate)	282.0	100.0	19,158	100.0	932

Sources: APHA/CHA education and training survey 2014–15; Department of Health 2015a; Department of Health 2015b.

Government data combined with survey results indicate vocational registrar positions are unevenly distributed across the sector. As shown in Table 8, half of all private hospital posts are concentrated in a small number of facilities. Each of these facilities had more than 9.0 FTE of vocational registrars in 2014–15 (Department of Health 2015a). The remainder are more sparsely distributed with the majority of private hospitals reporting between 1.0 and 3.0 FTE.

Table 8: Estimated vocational registrar positions, by private hospital peer group

AIHW HOSPITAL PEER GROUP	VOCATIONAL REGISTRAR (FTE)	PROPORTION OF TOTAL (%)
Private acute group A hospitals	139.1	49.3
Private acute group B hospitals	47.7	16.9
Private acute group C hospitals	13.5	4.8
Private acute group D hospitals	11.4	4.1
Private acute psychiatric hospitals	33.4	11.9
Private rehabilitation hospitals	16.9	6.0
Day hospitals	14.1	5.0
Other	5.8	2.1
Total	282.0	100.0

Source: APHA/CHA education and training survey 2014–15.

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If the role of the private sector in vocational registrar training is to expand to meet rising demand for training opportunities and projected skill shortages for medical specialties, colleges and government agencies will need to engage with a diversity of private hospitals to access the wide range of opportunities available.

Private hospitals and medical training

Survey respondents recognised the benefits of private sector involvement in medical training, particularly in relation to vocational registrars. However, these benefits were dependent on a number of factors including: the specialty concerned, the extent of clinical education support available, the attitude and availability of CMOs, and the level of experience and quality of the trainees themselves.

“Overall, the impact is positive. Vocational training registrars add value by improving clinical models, practise evidence-based medicine, and the provision of their training is an important part of continuing professional development and maintenance of standards for consultants. Having advanced trainees in some surgical specialties improves access to emergency and after-hour care for patients.”

[PRIVATE ACUTE GROUP A HOSPITAL – METROPOLITAN]

“Delivering specialist/intern training depends on the specialty of the intern. Generally, it is a drain on service capability, slowing procedures and increasing consultation times but in some disciplines (notably general surgery) medical postgraduate trainees absorb some of the less skilled work, freeing specialist time up to deliver increased capacity.”

[PRIVATE HOSPITAL GROUP WITH ACUTE HOSPITALS OF VARIOUS SIZES – METROPOLITAN]

“We have a senior registrar in geriatrics/aged care funded by [the specialist training program]. This has enabled us to accept more admissions and provide greater continuity of care for our busy medical ward (34 beds).”

[PRIVATE ACUTE GROUP C HOSPITAL – METROPOLITAN]

“Having registrars at the hospital assists visiting psychiatrists with inpatient admissions and potentially increases the number of patients that can be seen. It improves the timeliness of access to services and assessment of patients. Impact depends on the calibre of each registrar and the number of registrars allocated.”

[PRIVATE ACUTE PSYCHIATRIC HOSPITAL – METROPOLITAN]

Some respondents identified negative impacts of providing medical training. Intern training was more likely to impact negatively on service capacity. Although there were advantages for organisational culture and succession planning, there were also significant costs.

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“Medical training is embraced through placement of medical students shadowing nurses in acute care. Collaboration exists with medical specialists providing education in many of our programs to staff... This supports a collegial environment and transparency of communication and a focus on patients being the centre of what we do... Training interns and junior medical staff requires significant investment (cost and people), specialists that are willing to do this and [it] has the potential to reduce clinical capacity.”

[PRIVATE ACUTE GROUP B HOSPITAL – METROPOLITAN]

“Intern placements build loyalty and provide some basic clinical and administrative assistance, but require significant levels of supervision until PGY2 [plus]. They are important in succession planning of the medical workforce.”

[PRIVATE ACUTE GROUP A HOSPITAL – METROPOLITAN]

There is potential for government agencies, private hospitals and medical colleges to work together to improve the continuity of funding and the effective use of training opportunities in the private sector.

“Rehabilitation registrar in training – [Specialist training program] funding has a positive impact on the delivery of health services. Unfortunately [the specialist training program] funding was withdrawn in 2015–16.”

[PRIVATE ACUTE GROUP D HOSPITAL – INNER REGIONAL]

While vocational registrar posts in some hospitals are well established and working well, there is scope for improvement in other locations.

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Medical training – Greenslopes Private Hospital, Ramsay Health Care

During the past decade the Greenslopes Private Hospital, part of Ramsay Health Care, has developed a clinical school that operates with the University of Queensland and now has more than 40 interns and 150 prevocational junior medical officers on site and on secondment to other private and public hospitals around Australia.

The Greenslopes training network offers posts in metropolitan and regional locations including Noosa, Kingaroy, Mackay, Tweed, Bundaberg, Hervey Bay, Mount Isa, Darwin and Alice Springs.

State Medical Director Dr Jim Houston said Greenslopes and Ramsay have the ability to offer access for junior doctors to a superior level of clinical teaching and with enthusiastic mentors, to circumnavigate the increase in the medical teaching and training void.

“Further to this, the teaching profile in these hospitals has persisted and expanded with demonstrated success. This is not only a great resource and benchmark for Ramsay hospitals in the future, but also opens up efficient training avenues for the doctors of the future.

“This broader commitment demonstrates that medical training in the private sector is not only good for business, but fulfils the private sector’s duty towards training,” Dr Houston said.

Medical Intern Training – The Mater Hospital Townsville

This program qualifies interns for general registration with the Australian Health Practitioner Regulation Agency.

The program involves intensive clinical medical orientation and 47 weeks supervised practice in accredited terms. This includes a compulsory term in the emergency department, in surgery and medicine. In addition to the supervised practice, interns must also be involved in a variety of learning experiences.

The program is delivered in partnership with Townsville Health and Hospital Services, offering interns a blended experience of private and public hospital systems.

The role of private hospitals in addressing workforce shortage

Analysis by Health Workforce Australia (HWA) and by others subsequently has identified a number of specific challenges in relation to the medical workforce:

- ▶ projected shortages in specific specialties
- ▶ a need to identify future skills requirements with particular reference to the services required to better cater for the growing burden of chronic disease
- ▶ a need to attract medical practitioners to regional and rural areas
- ▶ the need to provide sufficient opportunities for medical graduates and junior doctors to complete the prerequisites for registration in their chosen specialty.

The private hospital sector has a valuable contribution to make to each one of these challenges. As already indicated, the private sector plays a prominent role in key areas of projected shortage. The private hospital sector is also a major provider of services to people living with chronic conditions including mental health, rehabilitation services and palliative care. Private hospitals provide these services in a variety of models including in-patient services, day programs and community/outreach programs.

The private hospital sector plays an important role in attracting medical practitioners to regional areas. Several groups, both for-profit and not-for-profit, operate networks of hospitals in regional locations, offering a variety of clinical experiences and close connection with local communities. More than 22% of private acute hospitals (accounting for 12% of acute beds) are located outside of major metropolitan centres (ABS 2016b).

There are a number of areas of medicine where casemix and models of practice in the private hospital sector are different from the public hospital sector. Without access to private hospital sector training, medical graduates risk missing out on sufficient exposure to important areas of medicine either because the number of cases in the public hospital sector is too few or styles of practice are not suited to or called for in the public hospital sector. Consequently, even in specialties where there are adequate training positions overall, there are still too few opportunities for trainees to gain experience in the private hospital sector.

“Advanced psychiatric registrar training is an important part of the development of the registrars since the private system has challenges that are very different to the public system.”

[PRIVATE ACUTE PSYCHIATRIC HOSPITAL – METROPOLITAN]

“Some medical/surgical specialties lack access to accredited training positions. Key examples in this hospital would be: [ear nose and throat] surgery, plastic surgery, ophthalmology, cardiothoracic surgery. In addition there are no advanced physician training positions in some key specialties such as: intensive care, medicine, cardiology, respiratory, gastroenterology, infectious diseases, neurology and stroke.”

[PRIVATE ACUTE GROUP A HOSPITAL – METROPOLITAN]

Summary

Government funding has significantly enhanced vocational registrar training in the private hospital sector. However, there are too few opportunities in some areas to meet anticipated skill shortages and to ensure trainees have access to experiences only available in the private hospital sector.

The private hospital sector is well-positioned to provide training opportunities in specialties of projected shortfall and in areas of medicine relevant to addressing the growing burden of chronic disease. Private sector training opportunities exist in both metropolitan and regional areas.

Future funding allocations and increases need to be matched to specialties of strategic importance and future requirements. They should also ensure interns and vocational registrars have appropriate access to a range of environments. Allocation of resources should ensure vocational registrars have access to training opportunities predominantly found in the private sector that complement opportunities available elsewhere.

On the whole, private hospitals see medical training as beneficial and strategically important. There is significant scope for expansion but several barriers to this remain, including:

- availability of supervision particularly for interns
- concerns regarding the impact of interns on productivity
- accreditation requirements preventing some private hospitals from qualifying
- the need for improvement in collaborative arrangements between public and private sectors
- a need for greater continuity of funding arrangements.

Recommendation 2

Governments:

- increase medical internship funding in the private hospital sector to provide employment opportunities for both Australian and international medical graduates
- develop minimum five-year funding agreements to enable stronger partnerships between stakeholders in the private sector and sustained investment in training
- expand and align funding for vocational registrar positions within areas of workforce shortage
- support expansion of vocational registrar training in light of opportunities only available in the private hospital sector.

Nursing and midwifery training

Private hospitals have a long history of providing training opportunities for nurses and midwives. In addition to providing clinical placements for students, they provide employment-based training for graduates, nurses seeking to enter or re-enter the profession, as well as postgraduate and internationally qualified nurses.

Enrolled nurses and assistants in nursing are crucial members of the nursing workforce in the private hospital sector. They enter their professions through vocational education and training programs either involving clinical placements (previously discussed) or traineeships where the trainee combines formal study with supervised employment.

Upon graduation from a recognised university or vocational education and training program, enrolled and registered nurses, and midwives, qualify for registration, but important aspects of their professional development remain. With this point in mind, many public and private hospitals have created graduate programs designed to ensure new graduates receive support, mentoring and guidance as they embark on their careers.

Nurses who do not qualify for registration in Australia or whose registration has lapsed must undertake formal programs prior to practising as either enrolled or registered nurses. These programs are subject to strict accreditation requirements, and only a few of these are available in the private hospital sector.

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These employment-based training opportunities are summarised in the following diagram:

		Pre-registration	Post-registration	Re-entry
Registered professions	Registered nurses and midwives	Programs for internationally qualified registered and enrolled nurses	Graduate placements for registered and enrolled nurses	Accredited programs for nurses whose registration has lapsed
	Enrolled nurses	Traineeships for enrolled nurses		
Non-registered professions	Assistants in nursing	and assistants in nursing		

In 2014–15, the most common type of formal training for nurses employed in the private sector was graduate placements. For the 68 hospitals reporting both staffing and training data in the survey, it was estimated 2% of nursing positions (FTE) were allocated to training. At the same time, there was significant variation between individual hospitals, reflecting their staffing profiles and strategic priorities.

Enrolled nurse training – Mater Hospital Brisbane

Mater Education is a nationally accredited, hospital-based independent Registered Training Organisation developing and delivering courses in a world-class clinical simulation facility.

The Mater Diploma of Nursing Program offers an opportunity to gain a Diploma of Nursing (Enrolled-Division 2 nursing).

Mater Education develops and delivers its own course material. Students learn contemporary best practice from clinical nursing experts and have the opportunity to gain hands-on experience across Mater's hospitals. The course is integrated and delivered onsite within Mater's South Brisbane campus.

Students can choose electives including emergency, mothers and babies, paediatric, diabetes anaesthetics, perioperative and palliative care. After 18 months full-time study (or three years part-time) graduates are eligible for national registrations as enrolled nurses. More than 230 students have graduated from Mater Education's Diploma of Nursing since 2010.

Graduate nursing programs

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Graduate nursing programs account for a large cost to private hospitals. In 2014–15, actual reported expenditure on graduate nurses was \$9.3 million (n=74). Estimated expenditure on graduate nursing programs for the private sector was between \$15.5 and \$16.5 million. In terms of volume and investment, graduate nursing programs are the most important nurse training programs for private hospitals. These include programs for registered nurses, enrolled nurses and midwives, often implemented as part of recruitment strategies or to establish a point of difference in attracting employees.

The size of these programs is usually matched to workforce demands. The cost of training graduate nurses is far less than the cost of providing medical internships and junior registrar positions where salary costs are included, because graduate nurses and midwives are not supernumerary positions. However, because recruitment of graduate nurses is matched to service demands, the number of places provided is liable to fluctuate year on year.

“Due to a lack of nursing vacancies [we] stopped offering a graduate nurse program some years ago since we could not justify the cost of the graduate program when we had no vacant positions to keep the nurses we had invested in. With the lack of graduate nurse positions available, [we] could offer a graduate program if the cost of the nurse was funded externally.”

[PRIVATE ACUTE GROUP B HOSPITAL – INNER REGIONAL]

Survey results suggest most of these programs are found in larger acute hospitals. They are found in only about a third of private acute group D hospitals, a little over half of all private acute psychiatric hospitals and a little under two-thirds of all private rehabilitation hospitals. Graduate programs are uncommon in other acute private hospitals and day hospitals (Table 9).

¹¹ Projected number of nursing graduates by HWA.

Table 9: Total estimated graduate nurse program positions (FTE) by hospital peer group

HOSPITAL PEER GROUP	NURSE GRADUATE (FTE)	PROPORTION OF TOTAL (%)
Private acute group A hospitals	550.0	39.0
Private acute group B hospitals	440.0	31.2
Private acute group C hospitals	260.0	18.4
Private acute group D hospitals	60.0	4.3
Private acute psychiatric hospitals	30.0	2.1
Private rehabilitation hospitals	40.0	2.8
Day hospitals	10.0	0.7
Other	20.0	1.4
Total	1,410.0	100.0

Source: APHA/CHA education and training survey 2014–15.

The total estimated number of places available in 2014–15 was small compared with the estimated 13,568 enrolled and registered nurses graduating in 2014 from Australian universities and VET programs (HWA 2014:72). Nevertheless, the private sector plays an essential role in enabling nursing graduates to enter the workforce.

Entry and re-entry programs

Survey respondents reported relatively few positions for entry and re-entry programs for registered nurses (15.6 FTE) (n=5). An additional two hospitals reported positions for registered nurses with international qualifications.¹² Due to the small number of responses, these data were not extrapolated to a sector-wide estimate.

Only a limited number of private hospitals were able to offer entry and re-entry programs for nurses, because they were required to meet external accreditation requirements.

The Australian Health Practitioner Regulation Agency website lists two private hospital sector organisations as providers of accredited re-entry programs for registered nurses:

- ▶ Hollywood Private Hospital, Ramsay Health Care Australia Pty Ltd
- ▶ San College of Education, within Adventist HealthCare Ltd.

Pathways for specialisation

Once registered, some nurses choose to undertake postgraduate studies to gain additional expertise in an area of specialisation. Some of these areas of specialisation, although not formally demarcated for professional registration purposes, are highly sought after in the private hospital sector. As a result, there were some examples reported where private hospitals provided support for nurses undertaking such programs. There were also instances where hospitals partnered with universities to provide programs leading to formal qualifications. Survey responses were not sufficient to estimate the extent of these activities across the sector.

¹² FTE not publishable due to small number of responses.

Mental health graduate nurse program

Perth Clinic's mental health graduate nurse program is improving patient care and outcomes and changing attitudes in the nursing workforce about choosing a mental health nursing career.

Perth Clinic, a 100-bed independent psychiatric hospital, has developed the Graduate Certificate of Clinical Nursing program in conjunction with Notre Dame University.

The course has promoted a culture of inclusion, openness and respect for patients. It has also helped maintain high calibre staff who are knowledgeable and well-equipped to provide a range of high quality treatment options. The hospital has also experienced low staff turnover, contributing to capacity across the workforce.

"The positive impact on patient care resulting from a dedicated and committed workforce cannot be underestimated and is seen in patient outcome data," said Perth Clinic Chief Executive Officer Moira Munro.

Expanding opportunities

The projected nursing shortage (HWA 2014) can only be met by a coordinated range of strategies. These include maximising the attraction and retention of new entrants and enhancing the skills of the existing workforce to participate effectively in new, more efficient models of care.

"There is a huge number of graduates but nowhere near enough graduate programs. There needs to be a significant increase in the amount of funding that goes towards these graduate programs. The graduates really need these structured supportive programs to flourish as highly skilled competent practitioners. It is becoming increasingly apparent that there is a very clear difference between clinicians who have been through a graduate program and those who have not."

[PRIVATE ACUTE GROUP A HOSPITAL – METROPOLITAN]

At the same time, as increasing efficiencies continue to be demanded of private hospitals, it is difficult to justify creation of supernumerary positions for new graduates. Many nursing roles in the private hospital sector require a level of skill and experience beyond the capabilities of new graduates. As the nursing workforce continues to age, balancing the need to recruit new graduates and to fill vacancies for higher-level roles will be an ongoing challenge.

Summary

While graduate nursing programs and training positions for nurses more generally are recognised as important, investment is driven by service requirements. For entry and re-entry programs, provision is limited by accreditation requirements.

There is both scope and interest within the private hospital sector to expand formal training for nursing graduates. However, development of training opportunities beyond immediate service delivery requirements necessitates external funding and a review of accreditation requirements.

Recommendation 3

Governments increase funding for supernumerary nursing and midwifery graduate positions at both registered and enrolled levels in the private hospital sector.

Allied health training

Private hospitals employ allied health professionals from a wide range of disciplines. They are either employed directly, or credentialed as private practitioners employed by third party organisations providing services to the hospital on a contractual basis.

A small number of private hospitals provide training opportunities for graduate allied health professionals and allied health assistants. However, the data (other than for clinical placements) were too sparse for detailed analysis.

Allied health covers a large range of professions, but the actual number of staff within any one profession may be low within a hospital. Consequently, graduate positions for any one profession tend to be small in number. At the same time, private hospitals provide valuable learning opportunities for allied health professionals, particularly in pharmacy, dietetics, physiotherapy, occupational therapy, and psychology. Furthermore, private psychiatric and rehabilitation hospitals in particular provide valuable opportunities for exposure to multidisciplinary models of team-based care.

Although training for allied health students and graduates is limited in scale, there is potential for private hospitals to contribute to more training, if an appropriate level of funding is forthcoming.

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Recommendation 4

Governments fund opportunities for allied health graduates in the private hospital sector.

Training the existing workforce

As well as contributing to the future workforce, the private hospital sector invests significantly in its existing workforce. This investment is used in three main ways:

- ▶ to foster professional development and leadership skills within the clinical workforce
- ▶ to ensure the safety and quality of clinical services
- ▶ to address skill shortages that cannot always be met by additional recruitment.

Professional development and leadership

Based on survey results, it was estimated the private hospital sector as a whole invested between \$15.0 and \$18.0 million in professional development and leadership in 2014–15.¹³ These activities included:

- ▶ external training: costs to the hospital for facilitating or enabling practitioners to attend external courses, conferences or other training and education activities run by other organisations, not including any general allowances paid in employee contracts
- ▶ continuing professional development: costs to the hospital for providing training and courses designed for participants to meet their continuing professional development requirements, other than training associated with safety and quality programs (this information was gathered in a separate survey question); these costs were regardless of any income received from participants and did not include any general allowances paid in employee contracts
- ▶ once-off organisational change: clinical or non-clinical training required as a result of significant organisational restructure or changes to work practices
- ▶ leadership: non-clinical training in management, supervision or administrative skills designed to increase the leadership and management skills of any staff at hospital level; this did not include training for leaders at the corporate level of hospital groups
- ▶ mission/community benefit: non-clinical training in an organisation's specific mission to provide healthcare services to the community.

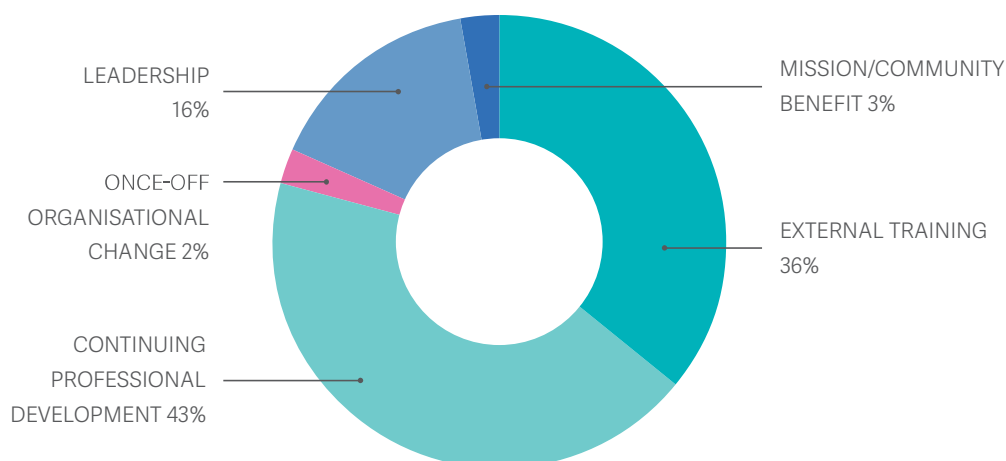
¹³ The actual cost reported for 2014–15 was \$7.8 million (n=86).

Some activities were specifically excluded from the survey:

- ▶ induction training not part of the training listed on the previous page
- ▶ training funded by vendors of technologies, equipment or drugs
- ▶ expenditure on employee entitlements above salary, e.g. continuing professional development allowances
- ▶ training or education directed at clinicians not providing care at the facility, e.g. education programs for referring general practitioners
- ▶ research, other than research undertaken as part of a formal training pathway by clinical staff entering or progressing to a higher level in their profession
- ▶ training or education for administrative and non-clinical staff
- ▶ training or education for staff at corporate level within hospital groups (i.e. not at facility level).

Figure 6 shows the distribution of costs reported by 86 hospitals.

Figure 6: Training for continuing professional development (other than safety and quality) and leadership reported by survey respondents (n=86)



Source: APHA/CHA education and training survey 2014–15.

It should be noted low response rates to this question from faith-based organisations resulted in underreporting of expenditure related to mission and community benefit. Expenditure on training relating to organisational change could be expected to vary from year to year.

Epworth HealthCare scholarship program

Since its inception in 2009, the Epworth HealthCare scholarship program has grown rapidly. More than 120 scholarships, valued at \$700,000, will be available to all staff in 2017 for a range of purposes including:

- attendance at local, national and international conferences
- completion of study tours and quality or service improvement projects
- return to further study.

In addition to general scholarships, Epworth also offers group study tour opportunities to innovative and pre-eminent international hospitals. Upon their return, staff are responsible for implementing a quality improvement project. The scholarship program is made possible through the generous support of corporate sponsors and private donors.

Safety and quality

Training to ensure safety and quality of clinical services is a high priority within private hospitals. When the National Safety and Quality Health Service Standards (NSQHSS) were implemented from 1 January 2013, there were several direct education and training implications for private hospitals. In the first instance, hospitals needed to ensure they were prepared for accreditation against the new standards. In many cases, this involved 'gap analysis' of systems and processes against NSQHSS requirements and general education of clinical teams using tools and resources provided by the Australian Commission on Safety and Quality in Health Care and accreditation agencies.

The NSQHSS mandated auditing a wide range of clinical practices, processes and policies, giving rise to a demand for training in auditing skills. In addition, the NSQHSS also listed several specific training requirements:

- open disclosure (NSQHSS 1.16.2)
- partnering with consumers (NSQHSS 2)
- hand hygiene (NSQHSS 3.5)
- invasive devices protocols and use (NSQHSS 3.9)
- aseptic non-touch technique (NSQHSS 3.10)
- basic life support (NSQHSS 9.6.1)
- advanced life support (NSQHSS 9.6.2)
- falls prevention (NSQHSS 10).

Survey respondents were invited to identify costs associated with training to meet the requirements listed, even if not carried out specifically for accreditation purposes. They were also invited to report costs against two general categories designed to capture the balance of training relating to safety and quality:

- other NSQHSS requirements
- other safety and quality-related training activities.

In the survey, 92 hospitals reported cost data against specific safety and quality activities. The total cost reported in the survey was \$12.5 million for 2014–15. About \$10.5 million of that was directly related to training to meet the NSQHSS requirements. Table 10 shows how the investments made by these hospitals were allocated. Provision of standard induction training was specifically excluded from the scope of this survey.

Table 10: Distribution of investment in safety and quality training (n=92)

ACTIVITY	NSQHSS	PROPORTION OF TOTAL COST (%)
Open disclosure	1.16.2	2.4
Partnering with consumers	2	5.6
Hand hygiene	3.5	12.3
Invasive devices protocols and use	3.9	4.3
Aseptic non-touch technique	3.10	7.0
Basic life support	9.6.1	7.6
Advanced life support	9.6.2	8.4
Falls prevention	10	6.9
Other NSQHSS training		29.5
Total NSQHSS training		84.0
Other safety and quality training		16.0
Total		100.0

Source: APHA/CHA education and training survey 2014–15.

It is estimated the sector as a whole spent between \$33.5 and \$38.0 million on training to support safety and quality in 2014–15. This includes between \$25.5 and \$29.0 million on training directly associated with the NSQHSS.

The average investment per FTE staff member varied between reporting hospitals. This variation may reflect accreditation activities with hospitals expenditure increasing in the lead up to more costly accreditation events. It may also have been a reflection of efficiencies available to some hospitals by virtue of their size or because they were part of a corporate group, providing economies of scale.

Online training tools appeared to have been widely used as a means of delivering mandatory training requirements as efficiently as possible. Some respondents said greater access to tools developed using government funds would be beneficial. Simulation training was also regarded as important, although only a minority of respondents reported access to simulation facilities: 10 reported onsite access and a further 15 reported access to a site elsewhere.

“Standardised training modules (for accreditation) and shared education and resource resources [could enable more training to be carried out].”

[PRIVATE HOSPITAL GROUP WITH ACUTE HOSPITALS OF VARIOUS SIZES – METROPOLITAN]

Hospitals in regional areas faced additional costs, particularly when it was necessary to send staff away for training.

“We have had recommendations to complete advanced life-support for our staff. It is difficult for rural staff to access trainers to train our staff, without the additional costings of transport and accommodation.”

[PRIVATE ACUTE GROUP D HOSPITAL – INNER REGIONAL]

It is notable that 85% of training costs associated with safety and quality were associated with meeting the requirements of the NSQHSS. Some hospitals reported these requirements drove their investment in education and training:

“Living in a regional area makes accessing training more expensive. [There has been] limited investment in recent times of training that doesn’t assist with meeting NSQHSS requirements.”

[PRIVATE HOSPITAL – INNER REGIONAL]

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Meeting skill shortages

Training plays a central role in addressing skill shortages that cannot always be resolved through recruitment. These skill shortages can arise from growth in services, the introduction of new services and/or changing technologies.

“Training is provided to meet the needs of the organisation and is directly linked to the strategic goals and staff skills required to provide safe patient care.”

[PRIVATE HOSPITAL GROUP B – METROPOLITAN]

Survey respondents identified training the nursing workforce as the top priority, with a focus on training in these areas:

- ▶ anaesthesia
- ▶ theatre nursing
- ▶ peri- and postoperative care
- ▶ intensive care
- ▶ paediatrics
- ▶ dermatology
- ▶ mental health
- ▶ renal care
- ▶ haematology and oncology
- ▶ wound care
- ▶ advanced life-support
- ▶ pain management
- ▶ diabetes management
- ▶ palliative care.

Clinical and technical staff with the skills and qualifications to work as theatre technicians and in areas such as central sterile services and catheter laboratories were also identified as being in demand.

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Palliative care in Tasmania

Calvary Health Care Tasmania developed and delivers an online postgraduate course with the University of Tasmania to ensure nurses have the necessary skills to provide appropriate end of life care.

The course ensures nurses are aware of appropriate care and the 'domains of distress' a person facing the end of their life will experience. The course puts a focus on patient-centred care and effective communication. This course addresses the need for a workforce that understands the needs of palliative care patients and their families.

Training priorities were identified at all levels of the nursing care team. The training of nurse unit managers and clinical educators was identified as a particular priority for some respondents. As discussed later in this report, clinical educators have become increasingly important in the private sector.

Nurse unit managers play a crucial role with high levels of responsibility, due to the workforce profile of the private hospitals sector. Providing training and career paths for nurses seeking to progress their careers is a priority as the nursing workforce ages.

St John of God nurse manager program

Effective nurse leadership is important in building a quality-oriented culture, according to St John of God Health Care.

This sentiment is behind the development and delivery of the nurse manager program, a 12-month course designed to support skills and boost the capabilities and confidence of nurse/midwifery managers.

The course has resulted in 90% of all nurse/midwifery managers achieving the business key performance indicators linked to the program and there has been evidence of team building and increased patient satisfaction and staff retention.

In 2016, as the result of feedback from nurse and midwifery managers, a Graduate Certificate in Nursing Leadership and Management was developed with the University of Notre Dame (Fremantle campus).

As well as identifying the need to develop the skills of registered nurses, several respondents highlighted the importance of developing the skills of enrolled nurses and assistants in nursing.

“There is a need to focus on improving the skills within the enrolled nurses and assistants in nursing to ensure that we can maximise their valuable contribution to providing care.”

[PRIVATE ACUTE GROUP A HOSPITAL – METROPOLITAN]

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Specific mention was made of the need to equip enrolled nurses working in chemotherapy, mental health and in the surgical hospital environment.

One skill shortage not reported in the survey was skills associated with digital health. Anecdotal reports collected by the APHA through separate processes suggest training in relation to clinical documentation and clinical coding has since been identified as a priority for many private hospitals.

For some, the solutions to these challenges involved the provision of on-the-job training and internal skill development.

“We have a program in place for staff to complete competencies in the clinical specialty areas. This provides a guide as to quality and performance requirements at different levels in nursing and allied health.”

[PRIVATE ACUTE GROUP A HOSPITAL – METROPOLITAN]

“Generally, nurses need to continue upskilling and brushing up on their clinical skills. Clinical education can always do more in terms of providing opportunities for staff to continue developing their procedural skills so that patient safety is maintained at a high level.”

[PRIVATE ACUTE GROUP B HOSPITAL – MAJOR CITY]

For others, formal qualifications and partnerships with education providers were identified as the best way to address skill needs.

“Increasing postgraduate and diploma opportunities for staff – we currently run neuro and graduate programs linked with university for postgraduate qualifications.”

[PRIVATE ACUTE GROUP A HOSPITAL – MAJOR CITY]

Summary

Private hospitals are major supporters of continuing professional development for clinical staff, funding either training provision or access to external training.

Training relating to safety and quality is the largest category of expenditure on training for existing staff. Training associated with the NSQHSS alone is estimated to have been between \$25.5 and \$29.0 million in 2014–15.

Meeting skill shortages within the existing workforce – particularly registered and enrolled nurses and theatre staff – is an urgent priority for private hospitals.

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Recommendation 5

Governments work with all stakeholders to increase access across the public and private hospital sectors to training materials, including e-learning resources developed with government funds to support the National Safety and Quality Health Service Standards.

Recommendation 6

Governments work with all stakeholders to address strategic skill and nurse workforce shortages.

Maximising capacity to provide education and training

Clinical educators and administration

Private hospitals are employing an increasing number of staff in training roles, either as clinical educators or administrators supporting education and training programs. Although it was not possible to estimate the size of this workforce for the sector as a whole, data provided by 77 hospitals totalled 289.9 FTE, of which 76.3% were nurses. Table 11 shows the distribution of this workforce across professions.

Table 11: Staff in specific education/training roles reported by respondents (n=77)

DISCIPLINE	NO. OF HOSPITALS REPORTING	REPORTED FTE	PROPORTION OF FTE (%)
Medical	7	6.7	2.3
Nursing	68	221.1	76.3
Allied health	3	1.4	0.5
Other	10	9.5	3.3
Management	35	31.5	10.9
Technical	6	4.5	1.5
Admin Support	18	15.3	5.3
Total	77	289.9	100.0

Source: APHA/CHA education and training survey 2014–15.

The role of clinical educators has grown in importance with the growth of clinical placement programs.

“The nursing and allied health departments of the organisation which this hospital falls under have developed a not-for-profit ‘fee per placement’ clinical deed that allows us to employ our own clinically trained staff to assess, plan and supervise students while on placement.”

[PRIVATE ACUTE GROUP A HOSPITAL – METROPOLITAN]

"We have a full-time facilitator for all undergraduate students while on clinical placement. The facilitators are almost 100% of the time hospital employees that are paid by the hospital and reimbursed by the universities. This is a good model, as we are able to provide our own staff with career opportunities by facilitating. If we are unable to provide facilitators the university assists."

[PRIVATE ACUTE GROUP B HOSPITAL – MAJOR CITY]

"All nursing and midwifery undergraduates are supported by paid facilitators in addition to the hospital staff preceptors in the clinical field. We are currently in the process to ensure that we have group-wide contractual arrangements with all universities placing registered nursing students at our facility."

[PRIVATE ACUTE GROUP A HOSPITAL – METROPOLITAN]

Some corporate groups coordinated these activities across multiple hospitals.

"Dedicated group clinical facilitator... National induction program online... Access to robust education calendar... Access to online training portal... Access to specialist clinical staff."

[PRIVATE HOSPITAL GROUP OPERATING ACUTE PRIVATE HOSPITALS]

"[Our group] provides lots of support in each state for the undergraduates. It is a brilliant service with resources and tools. Plus assistance with bookings. The new [computerised] education booking system has just been made available."

[PRIVATE ACUTE GROUP C HOSPITAL – INNER REGIONAL]

Support of this kind was identified as crucial to the provision of clinical placements. However, it was not always funded by universities. The cost of administration alone was significant.

"The overarching education manager maintains the facilitator team within normal hospital work hours over and above tertiary monetary support. Students are also supported by the general staff working on the floor with them on a day to day basis."

[PRIVATE ACUTE GROUP A HOSPITAL – MAJOR CITY]

Providing services to students and trainees

In addition to providing access to educators, mentors, preceptors and supervisors, some private hospitals have developed extensive programs of support for undergraduates to assist them in their studies and career education and networking. Some respondents reported employee assistance programs and counselling services were also available.

Private hospitals play an important role in supporting students and junior clinicians in considering their future career options. Libraries, online learning and study areas are provided, particularly in larger hospitals with established resources dedicated to learning.

Some private hospitals also provide employment opportunities while students are completing their studies:

“Hospital policies and procedures are available as well as access to in-house education... Undergraduates are welcomed into all areas including theatre. Undergraduates are employed as registered nurses in training or allied health assistants to allow them more exposure to the hospital environment while they complete their studies.”

[PRIVATE ACUTE GROUP B HOSPITAL – MAJOR CITY]

Although it was not possible to quantify the level of service provided, descriptions of the range of services indicates the comprehensive nature of support provided at some hospitals. Some of these services were required in order for hospitals to obtain formal accreditation.

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Some of these requirements may have been barriers to the accreditation of training opportunities in smaller facilities and day hospitals or in facilities where only a small number of training positions were provided. However, it was outside the scope of the survey to quantify this issue, and it is a matter for further investigation if the potential contribution of the private hospital sector is to be realised.

Increasing training capacity, relevance and effectiveness

Private hospitals have increased their training capacity, relevance and effectiveness through multidisciplinary training, alternative modes of delivery and investment in infrastructure.

MULTIDISCIPLINARY TRAINING

Some respondents advised that an increased use of multidisciplinary training would enable more training to be carried out. It was identified as important to supporting the quality and currency of clinical practice and as a point of difference in attracting employees.

“There needs to be a greater focus on multidisciplinary training simulation to enhance the effectiveness of the teams in the clinical workspace.”

[PRIVATE ACUTE GROUP A HOSPITAL – METROPOLITAN]

ALTERNATIVE MODES OF TRAINING DELIVERY

Innovative approaches to increasing training delivery in the private hospital sector include short online videos, social media and interactive gaming. This is already occurring in some hospitals, particularly larger hospitals with extensive investment in formal training programs, and the capacity to deliver training in a wide range of modalities.

“[We are] currently using education modalities such as e-learning, simulation, face-to-face, lectures, bedside tutorials.”

[PRIVATE HOSPITAL GROUP WITH ACUTE HOSPITALS IN VARIOUS SIZES]

Across the sector, the ability to access online learning, training videos and simulation technologies is becoming increasingly important.

SIMULATION TECHNOLOGIES

Despite simulated learning being identified as important, access to simulation technologies appears to vary across the sector. In 2012, Simulation Australasia developed the Simulation in Health Directory with funding from the Australian Government. The directory identified 147 onsite simulation providers in universities, TAFEs, hospitals and other health facilities across a number of health professions (Simulation Australasia 2012). This directory is no longer available online.

Many of these facilities were developed with government support including some flagship facilities in the private hospital sector. The benefits of this shared investment need to be fully realised.

“More simulation training with a specific and dedicated simulation training staff with suitable qualifications that can train nurses, doctors, and allied health staff.”

[PRIVATE ACUTE GROUP A HOSPITAL – METROPOLITAN]

Some survey respondents wanted greater collaboration with local universities to provide in-house training and increased access for hospitals to university amenities including simulation laboratories. Others indicated they would like to provide more simulation training but lacked the necessary facilities due to shortage of space and/or budget.

These comments suggest there is scope for further research on the availability and use of simulation facilities across both the health and education sectors to ascertain the impact of government and non-government investment.

INVESTMENT IN INFRASTRUCTURE

A lack of dedicated facilities can be a limiting factor in the provision of training. Private hospitals and private hospital groups have addressed this challenge in a variety of ways, including by broadcasting training programs online within their group to overcome the need for staff to travel to access training.

Some hospitals have had the opportunity to include provision within capital development plans for training facilities, including simulation training environments. However, the lead times for these investments mean that expansion of capacity is gradual.

“[We would like to provide] specific education facilities with simulated learning environment and auditorium facility. These are included in planning for a future development but are unlikely to be available for some years.”

[PRIVATE ACUTE GROUP B HOSPITAL – INNER REGIONAL]

Some hospitals have been able to access government funding to build or acquire such infrastructure and others have funded these activities with the assistance of benefactors and private fundraising.

Clinical schools and other partnerships with education providers

Some private hospitals, both large and small, have taken their support for education and training a step further and established their own clinical schools and formed relationships with particular universities. These include:

- ▶ Adventist Healthcare Limited
- ▶ Epworth Healthcare
- ▶ Greenslopes Private Hospital
- ▶ Joondalup Health Campus
- ▶ Lady Davidson Private Hospital
- ▶ Mater Health Services
- ▶ Perth Clinic
- ▶ St John of God Health Care
- ▶ The Melbourne Clinic
- ▶ The Wesley Hospital.

These partnerships have taken many different forms. Some are large and longstanding while others are smaller and more recent. Several have been featured as case studies throughout this report, providing examples of where closer collaboration between private hospitals and education providers has resulted in innovative and effective approaches to clinical education.

Macquarie University Health Sciences Centre integrating education and research with clinical care to improve lives

Macquarie University Hospital was created by Macquarie University as Australia's first and only private academic hospital owned and operated by a university, situated on a university campus. This structure has created opportunities. The integration of a hospital and university offers students professional practice and practical experience modules at each stage of their program.

Macquarie University has also established a new company (Macquarie University Clinical Associates) to employ medical specialists who will treat patients in hospitals as well as teach and conduct research.

Vice-Chancellor Bruce Downton says "this new model better integrates clinical care and research leading to improved patient care".

Some private hospital providers have also established educational organisations within their own hospital group:

- ▶ Mater Education Limited, Mater Health Services
- ▶ Mercy Health Training Institute, Mercy Health and Aged Care Inc.
- ▶ Ramsay Training Institute, Ramsay Health Care Australia Pty Ltd
- ▶ San College of Education, Adventist Healthcare Ltd.

Some provide training to their own clinical workforces as well as external students and organisations. The value of external training services has not been included in the data presented in this report, and it has been excluded from estimations of the overall sector's investment in education and training. However, these training organisations provide a valuable resource to the health sector as a whole.

Vocational education and training – San College of Education

Sydney Adventist Hospital's San College of Education's enrolments have grown tenfold since it opened in 2003. A registered training organisation, it initially provided training for non-clinical staff including wardsmen, patient service advisors and blood collectors, aiming to grow employee skills while demonstrating hospital standards.

It built on an extensive hospital history of education that began with nursing training in the early 1900s. That evolved to include nurse refresher and re-entry courses, continuing professional development courses for general practitioners, public forums, medical intern training, and most significantly, the opening in 2011 of a fully-fledged medical school in partnership with The University of Sydney.

The San College of Education is an important part of the hospital's education delivery according to Principal of the College, Deanne Portelli.

"Sydney Adventist Hospital was happy to go through the rigorous process to achieve registered training organisation status since it matched our commitment to service excellence and to providing training and growth opportunities for our staff," she said.

"We wanted to develop specific training programs for staff that were relevant to the work they were doing, in the environment they were working.

"With close to 1,100 non-clinical staff working alongside our 1,300-plus nursing and medical staff, we knew there was a lot of opportunity to improve standards and create potential career paths."

In 2003, the first courses offered included Certificate III in Health Services Assistance providing non-clinical staff with infection prevention, safe handling, cleaning, and communication skills. The San College of Education also provides courses in first aid, anaphylaxis, asthma, medical terminology, training and assessment, and resuscitation.

Barriers to expansion of training

Strategic and operational priorities, such as the introduction of new services or systems, play a major role in decisions regarding investment in education and training. For some respondents, expansion of training activities is contingent on meeting financial targets. Mandatory training requirements take priority.

Almost all respondents reported the challenge of managing tensions between clinical service priorities and training. This played out in allocation of resources, difficulties in backfilling clinical roles to enable staff to attend training, and difficulty persuading clinical staff to take on supervision and assessment of students and trainees. These challenges were encountered by hospitals of all types and sizes.

"[Barriers to investment include] availability of staff to be back filled from clinical shifts – sometimes called to work... funding for clinical educators in supernumerary roles."

[PRIVATE ACUTE GROUP B HOSPITAL – METROPOLITAN]

Some respondents noted capacity of dedicated education space was sometimes a barrier to expansion of training.

“Capacity of education space was the main limiting factor in deciding not to run some programs... Clinical education capability under different supervision models caps the number of students able to be trained in wards, theatres, intensive care units, emergency etc. Constant pressure to focus hours of staff on direct patient care rather than education prevents some course delivery from going ahead.”

[HOSPITAL GROUP OPERATING PRIVATE ACUTE HOSPITALS OF VARYING SIZES]

“Physical environment limits number of students from different disciplines as we do not have specific educational facilities e.g. offices, quiet spaces, technology.”

[PRIVATE ACUTE PSYCHIATRIC HOSPITAL – METROPOLITAN]

The physical size of a facility can be a limiting factor to training. One reported patient numbers limited the number of students they could accommodate.

“One of the barriers is the facility size. Smaller facilities with less infrastructure must be vigilant with the hours required of staff to undertake training and also the cost of staff to replace them while they are undertaking the training. It is often difficult to send more than one staff member per specialty to courses etc.”

[PRIVATE ACUTE GROUP B HOSPITAL – MAJOR CITY]

Hospitals in regional areas reported additional barriers due to the added expense to both the organisations and individuals of enabling staff to travel to attend external training:

“Increased costs for course attendance is always a factor, especially when we have to factor in hours, travel costs and accommodation to attend courses i.e.: rural facility, we could add \$600 to a course cost.”

[PRIVATE ACUTE GROUP D HOSPITAL – INNER REGIONAL]

Other barriers arose because of the diverse nature of the private sector. As already discussed in previous sections of this report, further consideration needs to be given to providing flexibility in accreditation requirements and to streamlining accreditation processes to enable the opportunities this diversity offers. In an environment of intense competition for both public and private resources, it is essential every effort be made to minimise administrative costs, including the costs of accreditation, so available resources can be focused on the delivery of effective training.

Maximising the value of available resources

Survey responses on the issues outlined in this chapter indicated a high level of interest from some private hospitals in innovation and development of strategic partnerships to increase training capacity for students and new graduates. Stronger relationships and longer-term funding agreements will facilitate establishment of larger, more efficient and more sustainable training opportunities.

The barriers identified need to be considered when allocating resources and designing government assistance and funding mechanisms. If this is done, a greater number of private hospitals and day hospitals could build capacity to provide training opportunities strategically important to individual facilities and to the sector as a whole.

It is important universities, VET providers, governments and employers work together to clarify expectations of work readiness. There is a need for all stakeholders to have a clear understanding of their respective roles and responsibilities so that the valuable opportunities for clinical training and experience within the private sector can be used to maximum benefit.

Summary

To increase their capacity to provide education and training to students, junior clinicians and the existing workforce, many private hospitals are embracing the need to:

- ▶ employ dedicated clinical educators
- ▶ provide services to students including mentoring, career advice and access to dedicated learning facilities
- ▶ develop innovative use of technologies including online learning and simulations technologies
- ▶ provide multidisciplinary training.

All private hospitals' capacity to provide training is shaped by their casemix, size and range of clinical services. However, some private hospitals face additional barriers including a lack of space and capacity to invest in dedicated infrastructure.

Private hospitals in regional areas face additional challenges due to the cost of accessing external programs.

There is significant scope for stakeholders to work together to maximise the benefit of the valuable training opportunities available in the private hospital sector.

Recommendation 7

All stakeholders work together to establish agreed and defined expectations of work-readiness for medical, nursing and allied health graduates seeking entry to internships and graduate positions in either the public or private hospital sector.

Recommendation 8

Governments examine access to and use of simulation facilities across the public and private hospital sectors and across the university and vocational education and training sectors to identify how best to maximise their use.

Recommendation 9

Agencies responsible for accreditation of training programs:

- ▶ revise accreditation processes so a wider range of facilities can qualify to be involved in the provision of training programs
- ▶ streamline processes to minimise costs associated with attaining and maintaining accreditation.

Measuring the impact of training in the private sector

The results of the survey show private hospitals play a major role in education and training and see this investment as strategically important. The private hospital sector invests in both the existing and the future health workforce. This investment has grown dramatically in the past decade in quantum, breadth and sophistication. It has been driven by strategic imperatives and partly enabled by government initiatives and funding support.

The survey and illustrative examples included in this report show private hospitals of all sizes are involved in training and specialised services such as private acute psychiatric hospitals and private rehabilitation hospitals have particular roles to play. While few day hospitals reported provision of clinical placements and training opportunities for junior clinicians, there are also some notable exceptions.

The lack of data capturing the extent of training and education activities in the private hospitals sector was one of the main reasons for undertaking the survey on which this report is based. While there are data on specific government initiatives and aggregate information on formalised training pathways available, there is no current, comprehensive overview available to show the contribution of the private hospital sector. Survey responses made it possible to create a snapshot of the private sector's involvement in education and training in 2014–15. Where possible, the report has placed results in the context of information on the wider health and education sectors.

Several recent government initiatives, including work commissioned by the Independent Hospital Pricing Authority (IHPA), have recommended improvements to data collection and it is essential that public and private hospital sectors collaborate so datasets and collections can be implemented across both sectors.

Future workforce supply, skill shortages, organisational priorities and the need to ensure the provision of safe, quality health services, mean education and training is a priority for the private hospital sector. However, the expansion of its role in developing the future clinical workforce would not have been possible without government funding and support. Even with this support, the private hospital sector's role in training the future workforce has yet to be fully realised.

Recommendation 10

All stakeholders collaborate to define a common dataset and improve the collection of data on clinical training and education.

Commentary – Paxton Partners

Paxton Partners is a provider of financial, performance improvement, business and management advisory services to the Australian health and human services sector. A consortium led by Paxton Partners was engaged by the IHPA to conduct a Teaching, Training and Research (TTR) costing study (the costing study).

The costing study followed on from a project the IHPA initiated in 2013, also conducted by Paxton Partners, to define TTR in the health sector and identify associated cost drivers for activity-based funding purposes (the definitions and cost drivers project). That project established nationally consistent, broadly accepted definitions for 'teaching and training' and 'research', identified a range of potential cost drivers for both concepts, and provided a framework for developing a classification for teaching and training.

Drawing from this experience, Paxton Partners was subsequently engaged by the APHA and CHA to provide technical, logistical and operating guidance to the methodology used to estimate the private and not-for-profit hospital sector's contribution to teaching and training. Our involvement assisted in the development, implementation, analysis and validation of survey results to derive the cost estimates used in this report.

The nature of Paxton Partners' roles for IHPA and APHA/CHA differed in a number of key respects,¹⁴ and underlined how differences in operating models, staffing structures, patient mix and funding arrangements currently manifest in different approaches to supporting teaching and training between the public and private sectors. Notwithstanding these differences, the practice of clinical teaching and training has played a longstanding and vital role in public and private hospitals across Australia.

However, data systems capable of identifying the costs and resources required to support teaching and training are still in relative infancy. As a result, recent work undertaken by both IHPA and APHA/CHA to understand the quantum of teaching and training activity and costs has had to rely on primary data collection processes and on the goodwill of interested hospitals to invest the time, effort and resources to collect relevant activity and cost data.

¹⁴ Paxton Partners' role in IHPA's work program investigated the feasibility of developing activity-based funding arrangements for teaching and training activities delivered in public hospitals across Australia by defining, costing and classifying these activities.

In contrast, APHA/CHA's work on teaching and training has sought to establish a foundation for estimating the scope and value of clinical teaching and training that is undertaken in the private hospital sector. It is therefore important to note that the nature of results presented in this report are not directly comparable to IHPA's teaching and training work program, which was undertaken for a different purpose, and uses a different methodology to achieve the project's aims. The outputs of the teaching and training work programs of IHPA and APHA/CHA should not therefore be compared on a like-for-like basis.

Considering the limited development undertaken to date in teaching and training data collections, this was not a straightforward task. No dedicated systems or processes existed in contributing hospitals to collect teaching and training data, particularly the substantial amount of teaching and training that occurs as an intrinsic by product of conducting patient care. Until robust, standardised processes are established for the collection, reporting and costing of teaching and training data, some degree of estimation will invariably be required to determine the costs, resources and activities consumed to deliver these activities.

With these factors in mind, and recognising that some level of estimation was required to derive the costed results, Paxton Partners considers that the approach adopted by APHA/CHA to estimate the private sector's contribution to teaching and training is reasonable, and represents a starting point for understanding the materiality of the sector's contribution to teaching and training.

Notwithstanding the infancy of teaching and training data collection requirements across the public and private sectors, it is clear from the work undertaken to date that these functions have material resource impacts for all hospitals. As a result, further development of data collection and reporting requirements will be a worthwhile investment to ensure that these resource impacts are properly understood, and can be managed and sustainably funded into the future. APHA/CHA's work represents a substantial step forward in understanding the private sector's contribution to delivering clinical teaching and training, and provides a basis for the further development of this important area into the future.

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Appendices

A: Methodology

GOVERNANCE

The project was devised as a joint project by the APHA and CHA and overseen by an advisory working group comprising representatives from both organisations:

- ▶ Caroline Hudson
- ▶ Rita Maguire
- ▶ David Rossiter (to August 2015)
- ▶ Keith Richardson (since August 2015)
- ▶ Jenny Williams.

Comments on the draft report were also provided by Maree Feery, Marlene Redelinghuys, Susan Cantwell, Wendy Bardsley, Jane Cleveland, Anne Spence, Elizabeth Porritt, Kathryn Clews and Jim Houston.

Each organisation undertook responsibility for liaison with its own members and the collection and analysis of data provided by members. Aggregate and de-identified results were then compiled as a single dataset and jointly analysed by the project team.

THE PROJECT TEAM

The research work and authoring of the report was undertaken by a joint project team comprising:

- ▶ Lucy Cheetham, Director Policy and Research, APHA
- ▶ Patrick Tobin, Director of Policy, CHA
- ▶ Peter McDonald, Manager Data and Research, APHA (June 2015–July 2016)
- ▶ Annette Panzera, Senior Health Policy Advisor, CHA
- ▶ Meke Kamps, Manager Data and Research, APHA (on leave June 2015–June 2016).

In addition, APHA and CHA contracted Paxton Partners to provide technical advice to the project team and to review the final report.

SCOPE

The survey aimed to capture a snapshot of data to quantify the level of activity and investment in clinical training and education in the Australian private hospital sector. While government funding programs have gathered some information, there are no statutory data collections which gather this information from the private hospital sector.

Member organisations of APHA and CHA were invited to participate in the survey on a voluntary basis. No attempt was made to capture data from non-member hospitals.

Because there are no statutory data collections covering the issues explored, it was recognised participants would have to undertake significant work to extract relevant information and data from administrative systems and records. As an incentive to encourage participation, APHA and CHA undertook to provide each organisation with a summary report on the information provided.

Responses were received from 99 private hospitals. A further 106 hospitals provided a limited subset of information in a follow up survey, conducted to encourage hospitals unable to complete the full survey to participate.

Information was sought on clinical placements for university and VET students and formal clinical training programs including programs funded directly or indirectly by government agencies. Information was also sought on programs devised/implemented by private hospitals and private hospital groups for new graduates and programs to support the development of clinical leaders, and/or more specialised skill areas. Finally, the survey asked some specific questions about investment in training directly associated with meeting requirements for the NSQHSS.

The survey specifically excluded:

- ▶ induction training not part of the types of training already listed above
- ▶ training funded by vendors of technologies, equipment or drugs
- ▶ expenditure on employee entitlements above salary, e.g. continuing professional development allowances
- ▶ training or education directed at clinicians not providing care at the facility, e.g. education programs for referring general practitioners
- ▶ research, other than research undertaken as part of a formal training pathway by clinical staff entering or progressing to a higher level in their profession
- ▶ training or education for administrative and non-clinical staff
- ▶ training or education for staff at corporate level.

The survey did not attempt to capture the total or depreciated value of investment in capital and equipment in relation to education and training although investment in the financial year 2014–15 was captured as part of the snapshot.

THE SURVEY INSTRUMENT

A survey instrument was designed by the project team to gather quantitative data on clinical training and education activity undertaken in private hospitals and the financial investment of private hospitals, and their parent groups, in this activity.

The survey also gathered free text answers to a range of questions about the benefits of investment in clinical training and the barriers to further expansion. This instrument was developed with guidance from the advisory working group, input from Paxton Partners and a workshop of participants facilitated by Paxton Partners. In August 2015, a pilot survey was run for a limited number of hospitals to inform finalisation of the survey tool.

Participants were provided with an excel spreadsheet and detailed instructions. Prior to analysis, the completed excel spreadsheets provided by participants were reviewed by their respective liaison officers. Summary reports were provided back to each participant for final sign off to ensure that the data provided were as complete as possible. Participants were also invited to provide short case studies qualitatively describing an aspect of their training activities. A selection of these case studies was included in the final report as illustrative examples.

PROFILE OF RESPONDENTS

Participants in this survey self-selected, through membership of a sponsoring organisation, and through committing resources to data collection. Survey responses were received from 97 private hospitals and two day hospitals. A further 64 hospitals and 42 day hospitals provided a limited subset of information.

These responses represent 60% of private hospitals and 18% of day hospitals in Australia. The responses covered 70% of beds in Australia.

Respondents were located as follows:

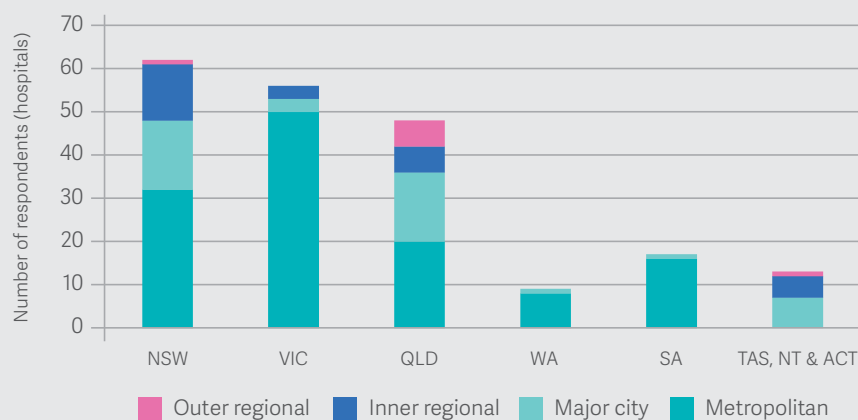
- ▶ 170 hospitals located in major cities of these, 126 hospitals were located in metropolitan areas
- ▶ 27 hospitals located in inner regional areas
- ▶ 8 hospitals located in outer regional areas¹⁵.

Respondents included:

- ▶ 154 hospitals belonging to for-profit hospital groups or independently for-profit
- ▶ 51 hospitals belonging to not-for-profit hospital groups

There was at least one respondent from each jurisdiction (Figure 7).

Figure 7: Private hospital respondents by jurisdiction and remoteness



A profile of respondents using private hospital peer groups developed by the AIHW is listed on page 8.

¹⁵ The ABS Australian Standard Geographical Classification Remoteness Structure allocates areas to 1 of 5 remoteness categories (Major cities, Inner regional, Outer regional, Remote and Very remote) depending on their distance from urban centres, where the population size of the urban centre is considered to govern the range and types of services available. This report has chosen to separate out cities with a population > 1 million, i.e. Sydney, Melbourne, Brisbane, Perth or Adelaide from the Major cities category and called these 'Metropolitan'.

EXTRAPOLATING THE ESTIMATIONS FOR THE PRIVATE HOSPITAL SECTOR AS A WHOLE

The estimates presented in this report were based on actual survey responses. Where data were submitted, these were taken at face value. For hospitals indicating they provided specific types of training but who did not or were unable to quantify it, an estimate of volume of training was created based on the average training profile of similar hospitals according to AIHW peer group, and bed numbers.

Because thirty Catholic hospitals were not able to provide data, it was assumed their involvement in clinical training was similar to non-Catholic hospital respondents in their relevant AIHW peer group.

Where possible, these estimations were compared against published sources and activity targets set for government-funded programs.

Cost estimates were created based on survey responses where matching pairs of cost and volume data were provided, to create an average cost per clinical placement day or FTE (depending on training type). Outliers were removed and average costs trimmed prior to applying this average cost to estimated volume.

No attempt was made to estimate average unit costs for the sector as a whole, due to the wide range of factors influencing these costs and the variability seen in the reported data. It should be noted this survey was not designed with this objective. Rather, the survey sought to estimate overall quanta of activity and investment in key areas of strategic importance to the health sector as a whole.

B: Acronyms

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ACRONYM	DEFINITION
ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
APHA	Australian Private Hospitals Association
APRA	Australian Prudential Regulation Authority
CHA	Catholic Health Australia
CMO	Credentialed medical officer
DET	Department of Education and Training
FTE	Full time equivalent
HWA	Health Workforce Australia
IHPA	Independent Hospital Pricing Authority
NMBA	Nursing and Midwifery Board of Australia
NSQHSS	National Safety and Quality Health Service Standards
MTRP	Medical Training Review Panel
PGY	Postgraduate year
TAFE	Technical and further education
TTR	Teaching, training and research
VET	Vocational education and training

C: List of participating hospitals

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Adelaide Day Surgery	Chesterville Day Hospital
Albury Day Surgery	Como Private Hospital
Albury Wodonga Private Hospital	Cotham Private Hospital
Armidale Private Hospital	Currumbin Clinic
Ashford Hospital	Darwin Private Hospital
Ballarat Day Procedure Centre	Dee Why Endoscopy Unit
Baringa Private Hospital	Donvale Rehabilitation Hospital
Barton Private Hospital	Dorset Rehabilitation Centre
Bellbird Private Hospital	Dubbo Private Hospital
Belmont Private Hospital	Dudley Private Hospital
Berkeley Vale Private Hospital	Epworth Cliveden
Brindabella Endoscopy Centre	Epworth Eastern Hospital
Brisbane Private Hospital	Epworth Freemasons
Brisbane Waters Private Hospital	Epworth Hawthorn
Brunswick Private Hospital	Epworth Rehabilitation Brighton
Caboolture Private Hospital	Epworth Rehabilitation Camberwell
Cabrini Malvern	Epworth Richmond
Cabrini Rehabilitation Brighton	Eye-Tech Day Surgeries
Cairns Day Surgery	Eye-Tech Day Surgeries Southside
Cairns Private Hospital	Figtree Private Hospital
Caloundra Private Clinic	Flinders Private Hospital
Calvary Central Districts	Frances Perry House
Calvary John James	Frankston Private Day Surgery and Peninsula Oncology Centre
Calvary North Adelaide	Geelong Private Hospital
Calvary Rehabilitation	Glenferrie Private Hospital
Calvary St Vincent's/ St Luke's	Glengarry Private Hospital
Calvary Wakefield	Gold Coast Private Hospital
Campbelltown Private Hospital	Gosford Private Hospital
Canberra Private Hospital	Greenslopes Private Hospital
Castlecrag Private Hospital	Griffith Rehabilitation Hospital
Chermside Day Hospital	

HealthCare Marian Centre	Marie Stopes International Townsville
Hillcrest –Rockhampton Private Hospital	Masada Private Hospital
Hobart Private Hospital	Mayo Private Hospital
Hollywood Private Hospital	Melbourne Private Hospital
Holy Spirit Northside Private Hospital	Metropolitan Rehabilitation Hospital
Hunter Valley Private Hospital	Mitcham Private Hospital
Hunters Hill Private Hospital	Mosman Private Hospital
Hurstville Private	Mount Hospital
Ipswich Day Hospital	Murray Valley Private Hospital
John Fawkner Private Hospital	Nambour Selangor Private Hospital
John Flynn Private Hospital	National Capital Private Hospital
Joondalup Health Campus – Private	Nepean Private Hospital
Kahlyn Private Hospital	New Farm Clinic
Kareena Private Hospital	Newcastle Private Hospital
Kawana Private Hospital	Ngala Family Services
Knox Private Hospital	Noosa Hospital
La Trobe Private Hospital	North Eastern Community Hospital Inc.
Lady Davidson Private Hospital	North Eastern Rehabilitation Centre
Lake Macquarie Private Hospital	North Queensland Day Surgical Centre
Lawrence Hargrave Private Hospital	North West Private Hospital – Qld
Linacre Private Hospital	Northpark Private Hospital
Lingard Private Hospital	Northside Clinic
Maitland Private Hospital	Northside Cremorne Clinic
Marie Stopes International Bowen Hills	Northside West Clinic
Marie Stopes International Broadmeadow	Norwest Private Hospital
Marie Stopes International Canberra	Nowra Private Hospital
Marie Stopes International East St Kilda Road	Pacific Private Day Hospital
Marie Stopes International Maroondah	Panch Day Surgery Centre
Marie Stopes International Midland Centre	Parkwynd Private Hospital
Marie Stopes International Newcastle	Peninsula Oncology Centre
Marie Stopes International Rockhampton	Peninsula Private Hospital – Qld
Marie Stopes International Southport	Perth Clinic

Pindara Private Hospital	Sydney Adventist Hospital
Pine Rivers Private Hospital	Sydney Day Surgery (Prince Alfred)
Port Macquarie Private Hospital	Sydney Southwest
Prince of Wales Private	Tamara Private
Queensland Eye Hospital	The Adelaide Clinic
Queensland Mater	The Attadale Rehabilitation Private Hospital
Regional Imaging Riverina	The Avenue Private Hospital
Ringwood Private Hospital	The Bays Hospital
Rivercity Private Hospital	The Burnside War Memorial Hospital Inc.
Shellharbour Private Hospital	The Cairns Clinic
Skin and Cancer Foundation	The Eye Hospital
Sole' Vita Surgery	The Geelong Clinic
South Coast Private	The Hills Private Hospital
South Eastern Private Hospital	The Hobart Clinic
Southern Highlands Private Hospital	The Mater Sydney Hospital
Southline Eye Surgery Centre T/A Vision Eye Institute	The Melbourne Clinic
Sportsmed SA Hospital	The Memorial Hospital
St Andrew's –Ipswich Private Hospital	The Sunshine Coast Private Hospital
St Andrew's Toowoomba Hospital	The Sydney Clinic
St Andrew's War Memorial Hospital	The Valley Private Hospital
St George Private Hospital	The Victoria Clinic
St Helens Private	The Victorian Rehabilitation Centre
St Luke's Hospital	The Wesley Hospital
St Vincent's Private Melbourne	Toowong Private Hospital
St Vincent's Private Sydney	Toowoomba Surgicentre
St Vincent's Private Toowoomba	Toronto Private Hospital
St Vincent's Private Hospital Brisbane	Townsville Day Surgery
Stirling District Hospital Inc.	Townsville Private Clinic
Strathfield Private Hospital	Tweed Day Surgery
Sunnybank Private Hospital	Victoria Parade Surgery Centre
Sunshine Coast University Private Hospital	Vision Centre Day Surgery
	Vision Day Surgery Camberwell

Vision Day Surgery Eastern
Vision Day Surgery Footscray
Vision Eye Institute, Chatswood
Vision Laser St Kilda Road
Wagga Endoscopy Centre
Wangaratta Private Hospital
Waratah Private Hospital
Warners Bay Private Hospital
Warringal Private Hospital
Waverley Private Hospital
Wesley Hospital Ashfield
Wesley Hospital Kogarah
Western Hospital
Westmead Centre
Wolper Jewish Hospital

