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Position Paper

Locums and short-term contractors in the health workforce

August 2012

This Position Paper is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

LOCUMS AND SHORT-TERM CONTRACTORS IN THE HEALTH WORKFORCE

Health services in rural and remote [1]areas have always benefited from the availability of locums to provide backfill for permanent staff. However the general shortages of health professionals across disciplines and in many areas have created the situation in which short-term staff, provided at great expense (often through commercial entities), are more and more being relied on to keep health services operational.

Locums

A locum is a temporary replacement for a health professional who is on leave for continuing professional development (CPD), family reasons or for recreation and who will return to the position on completion of their leave. Ready access and availability of locums for rural health professionals is crucial in providing ongoing care for patients and good working conditions for staff, and for retaining permanent clinicians in rural and remote communities.

The Australian Government funds several locum programs for general practitioners, specialists[2], nurses, midwives and specified allied health professions[3]. These programs cannot be used to fill vacant positions; are available for a limited time only (up to 14 days in a year); and provide limited subsidies and support including travel and accommodation costs. The organisations that administer the general practice, nursing and allied health locum programs also provide additional assistance and support for locums to prepare for rural practice. These programs provide very welcome relief for rural and remote practitioners, but limited funding means that many rural practitioners seeking a locum miss out or receive a subsidy for only a portion of the time that the locum is employed. Locums who come from city areas may not be well prepared for rural practice, particularly general practitioners, who may also need to provide emergency services as a visiting medical officer at the local hospital. The Rural Locum Education Assistance Program (Rural LEAP)[4] assists urban GPs to train in emergency medicine if they commit to a four-week paid general practice locum placement in a rural location within a two-year period.

Issues that arise:

- Not-for-profit locum programs are oversubscribed and do not meet the need for locum relief, particularly for nursing and allied health professions.
- The quantity and quality of orientation and support provided for locums varies across jurisdictions and between professions.
- It is not known how many practitioners who complete the Rural LEAP go on to provide locum services under other government-funded locum schemes.
- Rural hospitals, Aboriginal Community Controlled services and rural practitioners in private business struggle to meet the costs of locums to cover the usual periods of leave that Australian workers take for granted (four weeks annual leave; sick leave; bereavement leave) - let alone the leave required for continuing professional development to meet accreditation requirements. Limiting government funded locum relief to only 14 days a year means that either the health professional does not take recreation or sick leave, or else leaves their patients with little or no access to health care.

[1] Throughout this paper the term "rural" should be taken to cover remote as well as rural areas.
[2] http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/content/NRLP
[3] http://www.nahrls.com.au/
[4] http://www.acrrm.org.au/rural-locum-education-assistance-program

- Inadequate leave from a busy practice, where long hours are the norm, can lead to burn-out or illness and contribute to health professionals leaving rural practice.
- Rural health professionals in publically funded health organisations see investment in locum staff as a positive retention strategy and are frustrated at what they perceive as short-sighted lack of funding for adequate locum coverage [5].
- Rural hospitals or other service providers often do not replace staff who take leave, particularly nurses and allied health professionals. The Nursing and Allied Health Rural Locum Scheme (NAHRLS) pays an incentive for the locum and provides travel and accommodation costs but does not pay the wages for the locum. This means that the service provider needs to pay the wages of the staff on leave as well as the wages of the locum. For many small providers this simply makes the cost prohibitive and positions are left unfilled while the incumbent is on leave.
- Many locums do not receive orientation or preparation for rural practice prior to commencing their rural placement, creating a range of difficulties such as culturally inappropriate care or lack of continuity of care.
- On arrival at the practice location and on completion of the locum period, it is essential that a 'handover' is provided - to bring the locum up to speed initially and to update the returning health professional of issues that have arisen or need to be addressed.
- Locums are often not perceived to have a role in training the next generation of health professionals, although in some rural health facilities they represent an important pool of supervision and teaching capacity for junior staff and university students.
- Practitioners who fly in and out on a regular basis report that at times priorities in a health service can change between visits, associated with changes in staff rather than changes in community need. Greater involvement and ownership of local health services by consumers and community members is seen as a strategy to address this issue.

Feedback from the Alliance's stakeholders has indicated that some communities have found successful ways of obtaining locum relief for their local health service providers.

- Some small rural hospitals and general practices have successfully developed ongoing relationships with large regional or city service providers to provide locums on a rotating basis throughout the year. This provides the urban practitioners with variety that many really enjoy. The locums who return on a semi-regular basis throughout the year build relationships with the health professionals they relieve, the patients and the community - thus minimising the risk of inappropriate care or lack of continuity.
- Where hospitals employ sufficient staff to adequately cover on-call rosters and factor in annual, long service, study and conference leave, the hospitals are more successful in recruiting locums or providing internal relief workforce. This can work well where locums come from 'district' locums or external sources. They must however be funded. The role of Local Hospital/Health Networks and Medicare Locals will become increasingly important in developing district or regional solutions.
- An example has been provided of a rural general practice that has employed many locums for holiday cover, paying approximately $1500 a day as well as pay for afterhours work when on call, accommodation and travel expenses and agency fees when necessary. The practice and its doctors recognise that the cost of locums can impact on income, especially when leaves overlap, and because locums often do not generate as much

[5] *The challenges confronting clinicians in rural cute care settings: a participatory research project,* Rural and remote Health 12: 2017 (Online) 2012

income as the incumbent. This commitment by the practice has resulted in sustainability of the practice with the doctors all working for many years, each having a minimum of six weeks' leave a year and three months' long service every seven years. The commitment comes from the doctors' view that it is important for their own sanity and important to provide cover for their patients when on leave. Allied health professionals in private practice face similar issues but because their income is significantly less than that of a GP, the income: cost ratio is more difficult.

- The Department of Health in Victoria set up a hospital pharmacy locum project, based on cost recovery. The pharmacist is located at a regional hospital and can be booked to provide locum services in surrounding hospitals. The project is reportedly very successful with the pharmacist booked up for many months. It is acknowledged that there is some risk for the hosting hospital, which makes a financial commitment to employ the pharmacist, that the locum will not be booked out all the time. Such a project may be less viable in a larger region where travel times and costs are greater.
- The Rural General Practice Locum Program has until recently been delivered by seven Rural Workforce Agencies which promoted the program, developed strong relationships with rural doctors and coordinated a national pool of locums that they could call upon and exceeded targets set by the funding body. From 1 July 2012 this funding has been directed to the 62 Medicare Locals some of which are working through the complexities of becoming established and are not ready to deliver these services. It is essential that the gains made through this program are not lost through the dispersed nature of the new delivery mechanism or the lack of central coordination, marketing and quality control.

Short-term contractors

The term 'short-term contractor' is used to refer to health professionals who are brought in to fill vacancies or to cover situations where there is an essential requirement for clinical coverage but there is no local health professional available. In rural towns, GPs often provide hospital and emergency services and may not be able to provide full time cover, especially on weekends or during leave for CPD or holidays. It should be noted that short term contractors are rarely brought in to cover allied health vacancies – many allied health positions are simply left vacant and may disappear if the position remains unfilled.

Frequently, short-term contractors are brought in from major cities or even from New Zealand on quite high rates of pay (such as $2000 per day). This situation also occurs in remote nursing clinics which are often staffed on an ongoing basis by agency nurses at higher rates of pay than permanent staff would be paid (such as $100 per hour). The price of short-term contractors usually includes additional costs for travel and accommodation as well as agency fees.

This situation runs a number of risks. For one thing, the cost of highly paid contract staff imported for a weekend or a week to keep a service operating endangers the financial sustainability of health services that are already under fiscal strain. The collective high costs of such staff are even threatening the financial sustainability of whole jurisdictional health services. The Alliance has also had reports of health services that have laid off regular part-time or even full-time staff in order to cover the costs of short-term contract staff in key positions.

Health professionals can earn much more working for a commercial agency which provides short term contractors and may therefore be reluctant to apply for permanent positions, contributing to the overall problem of unfilled positions.

The Alliance received feedback from several stakeholders that a significant reason for ongoing vacancies or inability to fill shorter tem positions is the inefficiency and length of the recruitment process in many rural areas. It has been suggested that in some situations this may be a strategy to manage budget restrictions. Recruitment that takes months to finalise is likely to result in applicants accepting other positions which are offered much more promptly. It has also been suggested that if the number of positions, conditions and remuneration were improved (using some of the resources that would otherwise be spent on short-term contractors), there may be fewer ongoing vacancies to be filled by costly short-term contractors or agency staff.

There are a number of issues that arise from hiring short-term contractors to meet ongoing staffing needs.

- It is recognised that short-term contractors need to be paid more as they do not have continuity of employment but the open market is pushing the price to unsustainable levels. High costs can result in budgets being blown out which may:
    - force temporary closure of facilities, such as small hospitals' Emergency Departments overnight, creating a perception of grave risks to patients; or
    - cause the health service to become unsustainable with the risk of closure creating even greater disadvantage for the health of the local community.

  These challenges relate to many different services and settings such as remote area clinics, Multi-Purpose Services, private practices in medicine and allied health, community health services and AMSs as well as small hospitals.
- State Health agencies (e.g. Tasmania) cannot afford to staff their rural facilities with short-term contractors and in some situations the cost of each contractor leads to a cut of more than one permanent staff.
- Some jurisdictions have capped the hourly rate payable for locum medical officers, but this rate then effectively sets a floor price for negotiations.
- Short-term contractors may not have appropriate training, skills, experience or cultural preparedness for rural and remote areas, with little knowledge of the town or the patients, the local health system, or rural health issues. This can result in inadequate and/or culturally inappropriate health care and lack of continuity of care.
- Short term contractors may work in a community for one-off short term periods. Lack of knowledge of the local medical culture, the capacity of the local system and GPs and lack of engagement in the 'intellectual foment' of the hospital can lead to hidden costs such as over-investigation; increased length of stay; or inappropriate transfer of patients to larger hospitals, thus contributing to overcrowding in regional hospitals.
- When short-term contractors are paid at very high rates compared with local long-term practitioners, the local clinicians feel undervalued and disgruntled. This is often compounded by 'metro-centric' attitudes of contractors who regard rural practice as somehow inferior. These factors can significantly contribute to recruitment and retention difficulties for rural health services.

Some successful situations have been described.

- The Remote Area Health Corps (RAHC) is an Australian Government funded initiative designed to attract urban health professionals to work for a short period in remote Indigenous communities in the Northern Territory where there is an essential requirement for a specific clinical service but there is no local health professional available. The following information was provided by the RAHC.

  > "RAHC placements are short-term, from 3 weeks to 12 weeks, and provide an alternative to agency locum services. RAHC provides support and training to orient and prepare the health professional for successful transition to the remote setting and covers transport costs to the location. The receiving health service provides accommodation once the health professional is on the ground and pays the health professional the usual remuneration for a health professional in the position. Health professionals are employed on a casual employment basis at the prevailing rate for the health service. This means there are none of the additional costs associated with agency staff.
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  > In addition, RAHC endeavours to assist health professionals to transition into permanent roles with the health services. RAHC has placed more than 435 health professionals in over 1,230 placements since its first placement in December 2008. The 'repeat rate' - the number of health professionals who undertake more than one RAHC placement - is 64% over the life of the contract and currently sits above 75%."

  The Alliance has received varying feedback regarding the success of the RAHC in meeting the needs of remote Indigenous communities and this is reflected in the *Evaluation of the Child Health Check Initiative and the Expanding Health Service Delivery Initiative: Summary Report*.[6] There are undoubtedly valuable lessons to be learned from this innovative strategy.
- The quality of recruitment and placement agencies reportedly varies considerably. Some agencies do a very professional job in preparing their locum staff for work in rural areas; consider the various needs of existing staff and the community; and provide excellent orientation and support (including professional development opportunities) for short-term contract staff. Feedback has suggested that there should be a standardised application form and a recommended employment package that focuses on supporting existing staff and services.

Recommendations

Decisions relating to the appointment of health professionals in rural areas, as elsewhere, should be based on a patient-focused approach to service systems. The needs and interests of the health professionals permanently in the field are next in importance, and then the requirements of the employers and staff contract agencies.

Overarching policies

- Detailed evidence on numbers of health professional positions and unmet need, analysed by region, should be the basis by which health authorities determine the need for extra staff. Such evidence - and decisions dependent upon it - should be open to the public and transparent.

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[6] *Evaluation of the Child Health Check Initiative and the Expanding Health Service Delivery Initiative: Summary Report*, Commonwealth of Australia 2011

- In terms of continuity of care, local knowledge and culturally appropriate care, the best solution is to have sufficient staff employed by a health facility to enable periods of leave to be covered from within the existing permanent staff. At State and Territory level, there must be recognition that all health professionals in rural and remote areas require leave (in the range of 8 – 12 weeks per year). In practical terms this means that staffing requirements should be calculated on the basis of a 42 week working year rather than a 52 week year, which is unsustainable. Rural Local Hospital/Health Networks (LHNs) need to be funded to ensure that these periods of leave can be covered, either from within the existing staff complement or by provision of locums.
- All national and jurisdictional workforce programs need to include strategies to ensure that either sufficient staff are employed by the LHN and/or that locums are available so that permanent staff can have a reasonable work-life balance.
- Greater use should be made of short-term supervised positions to provide rural and remote clinical experience to young health professionals, including trainees and new graduates.
- Rural and remote locum programs and health service employers should ensure locums and short-term contractors are aware that they may have junior staff or students under their supervision during their period of employment. Where possible, locums and short-term contractors should be given support and encouragement to contribute to the teaching given by the host facility to junior staff and students.

General recruitment

- State and regional health authorities should give greater consideration to enabling shared arrangements between different clinicians, including individuals in neighbouring towns. This would require open communication with communities about their expectations for health services of various types and at various times. Medicare Locals in rural areas will be key bodies in identifying health workforce gaps in both the private and public sectors, the best means by which they can be filled, and keeping their local community well informed.
- Local Hospital/Health Networks need to include, in their staffing complement, sufficient numbers of health professionals to cover periods of leave for continuing professional development, recreation leave and personal leave for all staff in all hospitals in the network. This could include a planned strategy of employing additional salaried staff (such as salaried medical officers backed up by registrars) to cover periods of leave in any hospital in the network or creation of specific locum positions whose occupant can be booked in advance as required (as described above in the Victorian hospital pharmacy locum project).
- A wide range of agencies deliver services to provide locum and short term contractors including commercial recruitment agencies, Medicare Locals and a range of non-government organisations across different disciplines. Recruitment and placement agencies for both locums and short term contractors should be required to meet specified standards covering such matters as:
    - application processes and employment packages which focus on supporting existing services and staff;
    - the needs of the community and existing staff being taken into account so that the arrival of locums or short term contractors will not have significant adverse implications;

  - ensuring that arriving staff have appropriate experience and are provided with appropriate training and orientation to the location and position they will be filling and that appropriate handover briefings are required at the beginning and end of the placement;
  - ongoing support for locum or short term contract personnel.
- Recruitment processes for permanent or temporary staff could be improved by:
  - increasing numbers of positions and improving conditions and remuneration (using resources that would otherwise be spent on short-term contractors); and
  - reducing the red tape and duplication so that the length of time taken to recruit permanent or temporary staff is shorter.

Locums

- Rural hospitals and practices should be encouraged to develop relationships with large regional or city hospitals or practices to provide locums on a rotating basis throughout the year (building up a 'stable' of regulars who visit for a specified time each year) or possibly 'job-swaps' for a period of time (fixed term staff exchanges between rural and urban workplaces).
- Rural hospitals and practices should also be encouraged to develop partnerships with training organisation or educators from a tertiary institution that needs situations for training. The educational institution may then be able to provide regular and predictable locum cover when staff need leave.
- Australian Government funded locum programs (such as the Rural GP Locum program, the Specialist Obstetricians Locum Program and the Nursing and Allied Health Rural Locum Scheme) and the Rural Local Education Assistance Program provide much appreciated assistance for rural health professionals and service providers seeking locums. However, these schemes are heavily oversubscribed and are unable to meet the needs of rural and remote health practitioners. A review of these programs is recommended to ensure that the investment in locum services is commensurate with the need for locums and locum support, to increase consistency and equivalence of orientation and support for all health professions.
- Locum programs should be required to match locum skills to practice needs and facilitate and promote return of locums to rural areas where they have been before, or placement contracts that will secure the services of locums willing to do longer stints in rural and remote communities.
- Rural Workforce Agencies administer government-funded locum programs and provide orientation and support for locums. The extent and range of these services should be increased to support a greater number of locums across all health professions and to include such support as mentoring, accommodation and provision of a vehicle.
- Given the range of different Government and commercial locum programs servicing rural Australia, it would be beneficial to create a central online site to promote locum programs, recruit rural locums and provide information about programs that are available.

Short-term contractors

The utilisation of short-term contractors is having a significant impact in all jurisdictions and is threatening the sustainability of health services in rural and remote communities. These communities can ill afford to lose local health services when their health outcomes are so poor compared with those of their city cousins.

- Rates of pay for short-term health professionals on contract should not be so high as to distort recruitment and retention programs for permanent staff in a particular health profession.
- Successful models for the deployment of short-term staff should be documented and replicated as appropriate or modified for the particular characteristics of a region or community. Such models would include partnerships between clinical practices and UDRHs, job sharing arrangements, service based on 'working holidays' for selected individuals, and recruitment of health professionals in major city areas for regular cycles of work in rural and remote areas.

Health Workforce Australia would seem to be the agency best suited to bringing together the wide range of stakeholders who would need to work together to resolve issues around the cost of short-term contractors to the health system. The stakeholders would include:

- all levels of government;
- health professional organisations;
- administrators of government funded locum programs and commercial recruitment organisations; and
- consumer groups.

The scope of the work to be done would include developing innovative solutions; building on lessons learned from the RAHC initiative; and developing cooperative shared arrangements with industries that create high or fluctuating demand on local health services.

Innovative solutions

- Regional solutions that reduce the need for short-term contractors should be built on (e.g. development of contingency plans for a small town where emergency patients can be transported to a nearby hospital with emergency coverage within an acceptable time);
- ways and means of achieving a balance between increasing numbers and remuneration of permanent staff within a region and the cost of short-term contractors;
- innovative ways of providing essential clinical coverage such as the use of telehealth and on-line consultations; and
- community engagement and education to develop an understanding and acceptance of new ways of providing services.

Building on the RAHC initiative

The RAHC has developed systems for recruitment, orientation and training, cultural preparation, travel and accommodation and rates of pay for their contractors which do not distort the prevailing rate of remuneration for local health staff. The RAHC has also been successful in achieving a substantial 'return rate' of their recruits so that over time a relationship may be built up between the health professional and the community where they provide services.

The lessons learned from the RAHC experience could assist in the creation of standardised processes and systems to be used by all agencies that recruit and place short-term contractors. One of the most contentious, but potentially most beneficial, principles would be to set a

system of remuneration that would not bankrupt local health services and would not cause permanent staff to wonder why they just don't become short-term contractors.

Shared arrangements with industries creating high or fluctuating demand

Industries which create high or fluctuating demands on local health services should be required to contribute to meeting the local community's needs. In some mining towns, mining companies bring in their own health staff for their employees in the mining town. Consideration should be given to how these companies can assist in meeting community needs for health services through cooperative or shared arrangements.

Attachment 1

Member Bodies of the National Rural Health Alliance

ACHSM	Australasian College of Health Service Management
ACN RNMF	Australian College of Nursing Rural and Nursing Midwifery Faculty
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare & Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANF	Australian Nursing Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
APS	Australian Paediatric Society
APS (RRPIG)	Australian Psychological Society (Rural and Remote Psychology Interest Group)
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	Council of Ambulance Authorities (Rural and Remote Group)
CHA	Catholic Health Australia (rural members)
CRANAplus	CRANAplus – the professional body for all remote health
CWAA	Country Women's Association of Australia
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRHSN	National Rural Health Students' Network
PA (RRSIG)	Paramedics Australasia (Rural and Remote Special Interest Group
PSA (RSIG)	Rural Special Interest Group of the Pharmaceutical Society of Australia
RACGP (NRF)	National Rural Faculty of the Royal Australian College of General Practitioners
RDAA	Rural Doctors Association of Australia
RDN of ADA	Rural Dentists' Network of the Australian Dental Association
RHW	Rural Health Workforce
RFDS	Royal Flying Doctor Service
RHEF	Rural Health Education Foundation
RIHG of CAA	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
ROG of OAA	Rural Optometry Group of the Australian Optometrists Association
RPA	Rural Pharmacists Australia
SARRAH	Services for Australian Rural and Remote Allied Health