Review of the National Rural Locum Program

Final Report

Prepared by Communio for:

Department of Health and Ageing

April 2011
# Table of Contents

List of Figures ................................................................................................................................. iii
List of Acronyms ............................................................................................................................... iv
Executive Summary .......................................................................................................................... 5
Introduction ....................................................................................................................................... 8
Background ....................................................................................................................................... 10
Overview of the demographics of the rural and remote medical workforce .................................... 11
Overview of Programs ....................................................................................................................... 14
Appropriateness of the NRLP .......................................................................................................... 27
Effectiveness of the NRLP .............................................................................................................. 40
Efficiency of the NRLP ................................................................................................................... 44
Summary of key findings .................................................................................................................. 46
Key findings for NRLP overall ........................................................................................................ 49
Reference List ................................................................................................................................... 53
Attachment 1: Review consultations ............................................................................................... 54
Attachment 2: Visibility of NRLP on Relevant Websites ................................................................. 56
Attachment 3: Results of literature scan ....................................................................................... 57
Attachment 4: Demographics of the rural medical workforce ....................................................... 66
Attachment 5: NRLP Survey Analysis ........................................................................................... 70
List of Figures

Figure 1: Schedule of Subsidy for SOLS ................................................................. 15
Figure 2: SOLS targets versus actual placements and days for specialists ............. 16
Figure 3: SOLS targets versus actual placements and days for GP Obstetricians .... 16
Figure 4: No of unsubsidised days — SOLS ........................................................ 17
Figure 5: % of overall SOLS placements by State/Territory Jul 06 to Dec 2010 ...... 17
Figure 6: Placements by RA location .................................................................... 18
Figure 7: Type of placement (public, private or combined) .................................... 18
Figure 8: Schedule of Subsidy for GPALS ........................................................... 20
Figure 9: GPALS Target and Actual Placements and Days ..................................... 20
Figure 10: GPALS Placement Locations .............................................................. 21
Figure 11: Arrangement of locum ....................................................................... 21
Figure 12: GPALS placements by duration (September 2009 to November 2010) .... 22
Figure 13: Summary of RGPLP subsidies ............................................................ 23
Figure 14: RGPLP target vs actual placements and subsidised days ..................... 23
Figure 15: Placements and subsidised days per state/territory Nov 2009 – Jun 2010 (Yr1) and Jul 2010 – Dec 2010 (Yr 2) ............................................................. 24
Figure 16: Placements by RA category by state/territory Yr 1 ............................... 24
Figure 17: Placements by RA category by state/territory Yr 2 ............................... 25
Figure 18: Type of Placement – Practice/Site* .................................................... 25
Figure 19: GPs Full Time Equivalent (FTE) per 100,000 population ..................... 66
Figure 20: Trends or changes to in medical practice and rural and remote Australia ...................................................................................................................... 66
Figure 21: Practitioner numbers by State and Territory and ASGC-RA .................... 67
Figure 22: FTE specialists per 100,000 population by ASGC-RA ........................... 67
Figure 23: Number of practitioners providing procedural services by type, state or territory and RRMA .......................................................... 68
Figure 24: Venn diagram illustrating numbers undertaking single or multiple procedures .......................................................... 69
Figure 25: Practice type by RRMA .................................................................... 69
Figure 26: Average leave wanted and average leave taken in weeks ...................... 69
# List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACRRM</td>
<td>Australian College of Rural and Remote Medicine</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AMWAC</td>
<td>Australian Medical Workforce Advisory Committee</td>
</tr>
<tr>
<td>ANZCA</td>
<td>Australia and New Zealand College of Anaesthetists</td>
</tr>
<tr>
<td>ASA</td>
<td>Australian Society of Anaesthetists</td>
</tr>
<tr>
<td>ASGC-RA</td>
<td>Australian Standard Geographical Classification – Remoteness Area</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>DoHA</td>
<td>Department of Health and Ageing</td>
</tr>
<tr>
<td>FTE</td>
<td>Full Time Equivalent</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GPA</td>
<td>General Practitioner Anaesthetian</td>
</tr>
<tr>
<td>GPAC</td>
<td>General Practitioners Anaesthesitans’ Committee</td>
</tr>
<tr>
<td>GPALS</td>
<td>General Practitioner Anaesthetian Locum Scheme</td>
</tr>
<tr>
<td>HWQ</td>
<td>Health Workforce Queensland</td>
</tr>
<tr>
<td>JCCA</td>
<td>Joint Consultative Committee on Anaesthesia</td>
</tr>
<tr>
<td>LOLS</td>
<td>Locums Online Service</td>
</tr>
<tr>
<td>NRLP</td>
<td>National Rural Locum Program</td>
</tr>
<tr>
<td>NSW RDN</td>
<td>New South Wales Rural Doctors’ Network</td>
</tr>
<tr>
<td>RA</td>
<td>Remoteness Area</td>
</tr>
<tr>
<td>RACGP</td>
<td>Royal Australian College of General Practitioners</td>
</tr>
<tr>
<td>RAHC</td>
<td>Remote Area Health Corps</td>
</tr>
<tr>
<td>RANZCOG</td>
<td>Royal Australian and New Zealand College of Obstetricians and Gynaecologists</td>
</tr>
<tr>
<td>RARS</td>
<td>Rural Anaesthesia Recruitment Service</td>
</tr>
<tr>
<td>RDAA</td>
<td>Rural Doctors’ Association of Australia</td>
</tr>
<tr>
<td>RDN</td>
<td>Rural Doctors’ Network</td>
</tr>
<tr>
<td>RGPLP</td>
<td>Rural General Practitioner Locum Program</td>
</tr>
<tr>
<td>RHWA</td>
<td>Rural Health Workforce Australia</td>
</tr>
<tr>
<td>RRMA</td>
<td>Rural, Remote and Metropolitan Area Classification System</td>
</tr>
<tr>
<td>Rural LEAP</td>
<td>Rural Locum Education Assistance Program</td>
</tr>
<tr>
<td>RWA</td>
<td>Rural Workforce Agency</td>
</tr>
<tr>
<td>SOLS</td>
<td>Specialist Obstetrician Locum Scheme</td>
</tr>
<tr>
<td>VMO</td>
<td>Visiting Medical Officer</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to Date</td>
</tr>
</tbody>
</table>
Executive Summary

Background
Communio was contracted to undertake an external review of the National Rural Locum Program (NRLP) in April 2010. The Review occurred in two stages.

Stage 1 focused on data available for both the Specialist Obstetrician Locum Scheme (SOLS) and the General Practitioner Anaesthetist Locum Scheme (GPALS) up until 30 June 2010. A report on Stage 1 was provided to the Department of Health and Ageing and was distributed to the administering bodies of SOLS and GPALS for comment.

Stage 2 reviewed data for these two schemes up until 31 December 2010 and included the Rural General Practitioner Locum Program (RGPLP).

Approach
In undertaking this review Communio has:
- undertaken a desktop review of available reports, data and program documents
- undertaken a limited literature scan and web site review
- conducted interviews with 22 key stakeholders
- distributed an electronic survey through the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), the Australian Society of Anaesthetists (ASA), the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP) which resulted in 244 responses
- contacted and surveyed a sample of rural hospitals with active operating theatres
- attended the ACRRM Conference in Hobart to canvas stakeholder views.

Structure of this Report
This report incorporates the findings from Stage 1, which focused predominantly on the NRLP overall and specifically SOLS and GPALS. Findings in relation to appropriateness, effectiveness and efficiency are detailed for the NRLP overall.

Key successes of the NRLP
The availability of practical support to assist rural doctors to access leave has been well established as necessary to help maintain a strong rural health workforce. The establishment of the NRLP has seen the direct funding of the administering bodies, and subsidy support for locum hosts to assist with the cost of locum fees and their travel costs. For those who have used these schemes this government funding is welcomed and well received.

All three programs have high levels of satisfaction from both hosts and locums. SOLS and RGPLP have met the program objectives. However, GPALS has been unable to meet these objectives and is currently being administered by the Department of Health and Ageing (DoHA).

The review has found that it is appropriate for the Government to provide support to rural doctors to enable access to leave in a manner that allows continuance of local quality health services. Benefits to the community have been well documented.

The subsidy levels cover approximately 50% of locum costs and were considered by stakeholders as a reasonable contribution towards offsetting the cost of employing a locum. The capping of 14 days per practitioner per year was also generally considered to be adequate.

Continued on next page
Key areas for improvement of NRLP

Although stakeholders have welcomed the NRLP, the review has raised questions as to whether a more efficient administrative structure would maximise the potential benefits of the program.

The appropriateness and efficiency of having three separate administering bodies for these schemes have been questioned through this review. Whilst there is strong support for the backing of the professional colleges / associations by SOLS stakeholders particularly, there is no strong evidence that this is a significant benefit for either SOLS or GPALS. Similarly, the efficiency of the double layer of administration for the RGPLP has also been questioned and there are arguments both for and against the maintenance of the two layers.

Stakeholder feedback indicated that the administering agency of a locum program should have a close relationship with the rural medical workforce and understand their needs. Bodies nominated as possessing these qualities include the Rural Workforce Agencies (RWA), Divisions of General Practice, ACRRM and some commercial locum agencies.

Stakeholders also noted the need for the administering agency to be able to ‘tap into’ a supply of locums, but not necessarily own the locum supply. To effect this, a national approach to locum supply is needed, with effective database management plus good relationships and networks between state and territory RWAs, Divisions of General Practice and medical colleges and associations.

The current model of the NRLP provides access to the subsidies for hosts who source locums through the individual programs. The review has found that this is not an effective way to ensure the provision of locum relief and/or subsidies to the practitioners most in need of support as this is a perceived barrier to access. Whilst one of the aims of the program is to build a supply of locums to provide relief to the rural medical workforce, it should not be necessary to attach the locum supply to any one program.

The current model of the NRLP does not define or target those General Practitioners (GPs) with potentially the highest need for support. Although SOLS and RGPLP are required to prioritise solo GP practices and solo practice towns, this does not necessarily translate into placements for this target group. A high number of placements are in AGSC -RA 2 locations which, although eligible for the program, are often not in the priority group.

None of the programs focus on catering for GP proceduralists with multiple specialties. Due to the difficulties in matching skills for this group it is acknowledged that replacement for leave often requires two or more locum placements. A simple method that enables these GP proceduralists to access the subsidies is required, along with a targeted communication strategy to inform them of the availability of the subsidy.

The NRLP has had limited reach to date. SOLS has reached approximately 25% of the rural and remote specialist obstetrician workforce, but less than 10% of GP obstetricians and 4.3% of all GPs with an obstetric speciality (ie multi-proceduralists). GPALS targets were set at 5.7% of GP Anaesthetists, yet this was not achieved. For the period July to December 2010, RGPLP already exceeded its targets for the whole year, however, given the capped nature of the funding provided for this program, this reach is less than 4% of eligible GPs.

Continued on next page
Executive Summary, Continued

Conclusion

There is no doubt that the NRLP has been a welcome initiative to those hosts who have used the program. There is also no doubt regarding the benefits of the support provided for rural clinicians to take recreational and professional leave, to address the costs of locum relief, and to aid in retention of the rural workforce. The NRLP in its current model partially provides this support.

It was never the intention of the NRLP to meet the needs of the entire rural medical workforce, but rather to provide support for those practitioners who were unable to access locum services through other subsidised locum programs or commercial agencies. SOLS has reached 25% of practising specialist obstetricians in RA 2 – 5 locations, however the limited reach of the other programs to date means the impact of the NRLP on sustaining quality and safety in rural practice and aiding retention would most likely not be widespread.

This report has identified the key successes of the program to date and the key weaknesses or areas for improvement for consideration.
Introduction

Purpose

The purpose of this document is to provide a consolidated report on the findings of the external review of the National Rural Locum Program (NRLP). The NRLP comprises the Specialist Obstetrician Locum Scheme (SOLS), General Practitioner Anaesthetist Locum Program (GPALS) and the Rural General Practitioner Locum Program (RGPLP).

Review

Communio was contracted to undertake an external review of the NRLP to assess the appropriateness, effectiveness and efficiency of the three programs, in supporting the Australian Government’s aim to provide Australians living in rural and remote areas with access to quality health care. A two stage process was implemented with:

- Stage 1 concentrating on SOLS and GPALS, using program data up to 30 June 2010
- Stage 2 on all three programs using program data up to 31 December 2010.

Review Method

Communio has used a triangulated approach to draw robust conclusions from the review, noting that no single data source would be sufficiently comprehensive.

Data from a range of sources including the academic and grey literature, online resources, stakeholder consultation, and program data has been reviewed.

Approaches were made to a range of stakeholders in order to gather a wide diversity of views. Stakeholders included individuals from peak bodies, as well as a number of obstetricians and anaesthetists, both those who have used the NRLP schemes and those who have not. A total of 22 interviews were conducted. A list of stakeholder is provided at Attachment 1.

A brief literature scan and a review of a range of relevant web sites were also undertaken to inform the review. The result of the literature scan is at Attachment 3.

The Australian Society of Anaesthetists (ASA), the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP) distributed an electronic survey to their membership/fellows as part of the review process. The aim of the electronic survey was to extend the reach of the consultation, and to seek the views of stakeholders including hosts, locums and those who have never used any of the programs. A total of 244 responses were received. An analysis of the electronic survey and a copy of the survey are provided at Attachments 5 and 6 respectively.

Twenty rural hospitals with active operating theatres were also contacted and sent a specific survey. A further 10 hospitals were contacted and were either unavailable to participate in the survey or no longer provided operating theatres.

Site visits with hosts from the various programs were also planned. However, due to tight schedules for the doctors concerned, surveys and email correspondence were used instead.

Continued on next page
Introduction, Continued

The following section of this report provides contextual information about the demographics of the rural and remote workforce. This is followed by an overview of the three programs, an analysis of the appropriateness, effectiveness and efficiency of the NRLP and a summary of key findings.

Attachments 1, 2 and 3 provide further detail on the method of the review, including a list of consultations, results of the website review and the brief literature scan. Further attachments expand and provide background information relevant to the discussion in the body of the report, including a full analysis of the survey results provided as Attachment 5.
Background

Introduction

The developed world is experiencing a significant health workforce shortage which is exacerbated in rural and remote areas. In keeping with its overarching objectives of providing quality health services to all Australians, the Australian Government has a particular focus on supporting the medical workforce in rural and remote areas.

The supply of the medical workforce, when considered as the number of doctors compared with the population of the area in which those doctors practise, is low to very poor in many rural and regional areas of Australia. Rural and remote communities experience higher levels of morbidity and mortality as well as different patterns of disease. There are also complex social, cultural and economic issues underpinning the health problems found in rural and remote areas (Holub, 1995).

The Australian Government funds a number of programs aimed at increasing the number and skills of, support for, and access to, quality medical practitioners in rural and remote areas.

The Rural Health Workforce Strategy as a result of the Rural Health Reform – Supporting Communities with Workforce Shortages 2009-10 Budget measure has seen a number of strategies introduced to strengthen rural workforce support which has included increasing the level of funding and reach of locum programs under the NRLP. Two significant platforms of the Strategy are:

- the scaling or gearing of incentives and return of service obligations to provide greatest benefits to the most remote communities where there is the greatest need
- transition of program eligibility to the new Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) system.

Rural and remote classification system

ASGC-RA and RRMA

From 1 July 2009, the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) system replaced the Rural, Remote and Metropolitan Areas (RRMA) system as the basis for determining eligibility for a number of rural workforce programs.

Remoteness Areas (RAs) are the spatial units that make up the ASGC-RA classification system. The RA categories are listed below, with workforce incentives available for categories ranging between RA2 to RA5.

- RA1 - Major Cities of Australia
- RA2 - Inner Regional Australia
- RA3 - Outer Regional Australia
- RA4 - Remote Australia
- RA5 - Very Remote Australia

RRMA allocates areas into seven categories from ‘Capital city’ through to ‘Other remote area’ based on a combination of straight-line distance from urban centres of various sizes, and population density. The RRMA classification is based on population figures and Statistical Local Area boundaries as at the 1991 census.

As the transition from RRMA to ASGC-RA has been a recent change, the majority of recent demographic data for the rural and remote GP workforce is still categorised in the RRMA system. Therefore the two classification systems will be referred to throughout this document.

---

Overview of the demographics of the rural and remote medical workforce

The National Minimum Data Set

As part of their arrangement with the Department of Health and Ageing (DoHA), RHWA, through the Rural Workforce Agencies (RWAs) in all states and the Northern Territory collects and compiles a National Minimum Data Set for RRMA 4 to 7 locations in relation to the rural and remote general practice workforce.

In order to provide context for this report, a summary of the latest data report is provided below with more detailed data provided at Attachment 4.

GP and Specialist demographics

According to the Medical Practice in Rural and Remote Australia: National Minimum Data Set 30 November 2009, the number of medical practitioners practising in RRMA 4 to 7 locations has been steadily increasing since 2002.

Rural and remote communities generally have a relatively low ratio of General Practitioners (GPs) proportional to their population. National figures for GPs Full Time Equivalent (FTE) per 100,000 population range from 97.0 in major cities to 47.1 in very remote regions.

Overall numbers of practitioners working in RRMA 4 -7 locations (now ASGC-RA 2 to 5) have been steadily increasing since 2002 and as at 30 November 2009 there were 4753 practitioners, which represents an increase of 71 practitioners from the previous year.

NSW has the largest number of practitioners overall (1303) and RA 2 is the location with the largest number of practitioners (2662).

Rural and remote communities generally have a relatively low ratio of specialist medical practitioners proportional to their population with major cities having 122 FTE per 100,000 population, compared with remote/very remote at 16 FTE.

Numbers and targets for locum placement

The provision of support for the rural workforce through access to locum services is known to be a factor in influencing recruitment and retention. One of the aims of this review to identify whether the number and targets for locum placement under the NRLP is appropriate.

Although the number of GPs continues to grow, the Rural Doctors Association of Australia (RDAA) state that this growth does not indicate increased availability of GPs over time, as the growth in the medical workforce has not kept pace with the rate of population growth. The RDAA has calculated that rural Australia is short at least 1800 doctors. The data shows that there are 4753 medical practitioners practising in RRMA 4 to 7 locations (4559 in RA 2 to 5 locations) as at 30 November 2009. This means that there are 4559 practitioners who potentially require locum relief support.

Only Victoria and Tasmania recorded an overall drop in practitioners, with these states recording a loss of 17 and 9 practitioners respectively.

Continued on next page

2 Ian Cameron, Retaining a medical workforce in rural Australia, MJA 1998; 169: 293-294.
4 RDAA Factsheet 1/2010 The medical workforce shortage in rural and remote Australia: The Facts.
Numbers and targets for locum placement (continued)

In relation to the RRMA categories, the most significant increase occurred in RRMA 7 where 24 more practitioners were noted. Most of this increase in RRMA 7 occurred in the Northern Territory and Queensland. In NSW RRMA 4 also recorded an increase of 21 practitioners.

Of the total number of practitioners, 556 or 12.1% are solo GP practices, which is a criterion for priority locum relief support. However, it is important to note that over 462 of these solo GP practices are in RRMA 4 and 5 areas so this does not necessarily mean that they are the sole GP practice in the town/location.

The data shows that the number of solo GP practices is decreasing steadily with 56 less reported in 2009 than 2008. However, the number of GPs working in group practices remained steady.

Known proceduralists

The number and proportion of known GP proceduralists is falling steadily, according to the data. The number of GPs practising in at least one procedural field has fallen by 72 from 934 in 2008, to 862 in 2009. The most significant drops were seen in South Australia and Victoria, which recorded losses of 23 and 22 practitioners respectively. Northern Territory dropped from 13 to 5 practitioners. NSW was the only jurisdiction which remained steady.

In relation to the RRMA categories, the most significant drop was seen in RRMA 5 which lost 51 known proceduralists. RRMA 6 and 7 remained relatively steady.

GP Anaesthetists

The total number of proceduralist GPs undertaking anaesthetics fell from 488 in 2008, to 438 in 2009. The largest drops were seen in Victoria and South Australia with losses of 34 and 13 practitioners respectively. NSW was the only jurisdiction where an increase of 6 practitioners was noted.

Of the total 438 known anaesthetic practitioners, 248 of these also undertake other procedures in either obstetrics and/or surgery.

Over four hundred (412) GP anaesthetists (GPAs) work in group practice but it is unknown if they work with other proceduralists who may be able to provide locum cover for them. It is known that 22 GPAs work in solo GP practices and that 66 GPAs work in group practices in RRMA 6 and 7 locations, which makes it likely they are solo proceduralists in the practice and town.

The number of GP anaesthetists/obstetricians/surgeons is an important factor when considering locum relief with the appropriate skill mix.

Continued on next page

---

5 Refers to non-specialist practitioners providing procedural services such as obstetrics, anaesthetics or surgery.
### Overview of the demographics of the rural and remote medical workforce, Continued

#### GP Obstetricians
The number and proportion of known GP proceduralists undertaking obstetrics has fallen by 40 (from 623 in 2008, to 583 in 2009). The largest drop was noted in South Australia with a loss of 21 practitioners. Significantly for a small jurisdiction, the Northern Territory recorded a loss of 6 practitioners, falling to just 3.

Of the total 583 obstetrics practitioners, 322 of these also undertake other procedures in either anaesthetics and/or surgery.

One hundred and fourteen obstetrics practitioners work in RRMA 6 and 7 locations, making it likely that they are solo proceduralists in the practice and town.

#### GP Surgeons
The number of known GP proceduralists undertaking surgery has fallen by 24 from 282 in 2008, to 258 in 2009. The largest drop was noted in Victoria with a loss of 18 practitioners. Northern Territory recorded a loss of 5 practitioners, falling to just 2. Of the total of 258 surgery practitioners, 184 of these also undertake other procedures in either anaesthetics and/or obstetrics.

#### Multiple proceduralists
The number and proportion of GP proceduralists with multiple procedural specialties (obstetrics and/or anaesthetics and/or surgery) has fallen by 23 from 360 in 2008, to 337 in 2009.
Overview of Programs

The NRLP

The NRLP is an element of the Rural Health Workforce Strategy and was developed to assist rural doctors to obtain locum relief for leave and professional development. The program provides relief to medical practitioners working in ASGC-RA 2 to 5, which ranges from ‘inner regional’ to ‘very remote Australia’. It contributes to the Australian Government’s overarching objective to provide Australians living in rural and remote areas with access to quality health professionals.

Each of the three programs comprising the NRLP is funded and administered separately. RANZCOG administers SOLS; the ASA administered GPALS up to 1 November 2010 (now currently administered by the Department of Health and Ageing); and Rural Health Workforce Australia (RHWA) administers the RGPLP.

SOLS overview

SOLS is administered by RANZCOG. It commenced as a pilot in 2006 and was used as a model for the subsequent NRLP schemes.

In 2004, the Rural Specialist Group of the Rural Doctors Association of Australia (RDAA) identified the shortage of obstetricians and lack of locum support and services in rural and remote Australia as a priority issue. At the same time, RANZCOG also noted that there was a ‘critical shortage of obstetricians in rural and remote Australia. Only 16% of the 1160 practising obstetricians reside and practice in rural Australia’ (AMWAC, 2004).

In addition to the shortage of obstetricians, the current rural workforce is ageing, with a median age of 56 years (Robson, Bland and Bunting, 2005). This leaves open the possibility that there will be continued and greater shortages, as older clinicians retire. The impact of a diminishing workforce on those who remain is extremely serious and will exacerbate what has already been described as a critical situation.

The inability of rural specialist and GP obstetricians to take personal leave and professional development leave underlines the vulnerability of current service provision and the very real disadvantages and risks faced by rural women in need of obstetric services.

In 2005, in collaboration with the New South Wales Rural Doctors Network (NSWRDN) and RANZCOG, the RDAA approached the Department of Health and Ageing (DoHA) for funding for a scoping study to investigate the establishment of a subsidised national locum scheme for specialist obstetricians practising in rural and remote areas.

The scoping study found there was a definite need to assist rural specialist obstetricians in obtaining affordable locum cover, in order to enable them to take much-needed study and recreation leave. It recommended that funds be made available for a pilot to trial a scheme based on its findings.

SOLS Pilot I ran from July 2006 to September 2007. It was followed by Pilot II which ran from October 2007 to September 2008. SOLS as a program commenced in October 2008 and is funded until 30 June 2011. In January 2009, SOLS was expanded to include GP obstetricians.

The aim of the SOLS program addresses the findings and outcomes of the scoping study and pilots described above. It aims to maintain and improve the access of rural women to quality local obstetric care by providing the rural and remote obstetric workforce (both specialist and GP obstetrician) with efficient and cost-effective locum support. The program aims to sustain safety and quality in rural practice by facilitating access to personal leave, professional development or breaks from ‘on-call’ commitments.

Continued on next page
SOLS overview, continued

SOLS supports clinicians working in rural and remote areas, defined as ASGC – RA 2 to 5. It operates by providing host doctors with subsidised support to offset the cost of obtaining a locum. Hosts are eligible for a maximum of 14 days of subsidised support per financial year, which can be taken as a block or a number of shorter placements. After this, hosts can use the SOLS program to connect with locums who will provide locum services, but no further subsidies are offered in that year.

Program outline

SOLS provides subsidies for locum costs, travel time and travel costs. In the most recent funding period, the subsidies offered were as follows:

<table>
<thead>
<tr>
<th>Cost</th>
<th>Information</th>
<th>Subsidy (ex GST)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specialists</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locum subsidy</td>
<td>Subsidy per day for maximum of 14 days per obstetrician per financial year</td>
<td>$1000</td>
</tr>
<tr>
<td>Locum travel time</td>
<td>Maximum per placement</td>
<td>$1000</td>
</tr>
<tr>
<td>Locum travel costs</td>
<td>Maximum per placement</td>
<td>$2000</td>
</tr>
<tr>
<td><strong>GP Obstetricians</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subsidy</td>
<td>Subsidy per day for maximum of 14 days per obstetrician per financial year</td>
<td>$750</td>
</tr>
<tr>
<td>Locum travel time</td>
<td>Maximum per placement</td>
<td>$750</td>
</tr>
<tr>
<td>Locum travel Costs</td>
<td>Maximum per placement</td>
<td>$2000</td>
</tr>
</tbody>
</table>

Figure 1: Schedule of Subsidy for SOLS

Locum subsidies have been determined based on approximately 50% of the current market rate although it is acknowledged that locum rates vary and can be much higher at times.

Continued on next page
Target placements and target days have been agreed for the SOLS program as below. The SOLS secretariat manages the program towards achieving these targets, keeping in mind the needs of the host while ensuring they stay within budget and within the guidelines of 14 days of subsidy payment per host per year. This may be taken over a number of placements.

Figure 2: SOLS targets versus actual placements and days for specialists

Figure 3: SOLS targets versus actual placements and days for GP Obstetricians

Continued on next page
A number of placements included both subsidised and unsubsidised days, but there were few wholly unsubsidised placements. The unsubsidised days were spread across all RAs, and occurred in all states and the Northern Territory (NT). However, the highest demand for unsubsidised days has occurred in RA 2 and 3 and in terms of jurisdictions, from Victoria and Queensland.

The number of unsubsidised days may suggest that rural and remote clinicians desire more than the 14 subsidised days SOLS currently offers. However, even with the unsubsidised days included, the average placement length for specialist placements from July 2007 to December 2010 has remained relatively constant at 9.25 days.

Figures 5 demonstrates the usage of SOLS by jurisdiction. Victoria has utilised the highest number of placements over the life of the program, accounting for 35% of all placements. This has become particularly pronounced for specialists since July 2009. The Queensland usage of both specialists and GP obstetricians has been consistent at 25%, while usage in NSW has fallen since July 2009.

The usage by South Australia, Western Australia, Tasmania and Northern Territory, although small, has remained relatively consistent over the life of the program.
Overview of Programs, Continued

<table>
<thead>
<tr>
<th>RA</th>
<th>Specialist Placements</th>
<th>GP Placements</th>
<th>Specialist Placements</th>
<th>GP Placements</th>
<th>Total</th>
<th>% of placements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>56</td>
<td>10</td>
<td>41</td>
<td>8</td>
<td>125</td>
<td>71%</td>
</tr>
<tr>
<td>3</td>
<td>12</td>
<td>15</td>
<td>5</td>
<td>8</td>
<td>40</td>
<td>23%</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>3%</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Figure 6: Placements by RA location**

The above table shows SOLS placements by RA category between 1 July 2009 and 31 December 2010. By far the largest percentage of specialist placements was in RA 2, however placements for GP obstetricians were spread between RA 2 and RA 3. Only a very small percentage of placements were in RA 4 and 5 locations.

The SOLS program is used across all jurisdictions and certain locations have used SOLS on multiple occasions. One of these locations has used SOLS on 20 occasions during the life of the program. There is no evidence to explain why some locations utilise SOLS often and other locations of similar size do not. Stakeholders suggest that influencing factors may be:
- the higher number of specialists and GP obstetricians within the location
- satisfaction with, and awareness of, the SOLS service
- already established locum replacement arrangements including utilising others within their practice or location.

<table>
<thead>
<tr>
<th>Type of placement</th>
<th>2006/07 SOLS Stage 1</th>
<th>2007/08 SOLS Stage 2</th>
<th>2008/09 SOLS Program</th>
<th>2009/10 SOLS Program</th>
<th>1 Jul–31 Dec 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spec</td>
<td>Spec</td>
<td>Spec</td>
<td>GPO</td>
<td>Spec</td>
</tr>
<tr>
<td>Public</td>
<td>70%</td>
<td>77%</td>
<td>67%</td>
<td>94%</td>
<td>57%</td>
</tr>
<tr>
<td>Private</td>
<td>16%</td>
<td>13%</td>
<td>31%</td>
<td>6%</td>
<td>35%</td>
</tr>
<tr>
<td>Combined</td>
<td>14%</td>
<td>-</td>
<td>2%</td>
<td>-</td>
<td>8%</td>
</tr>
</tbody>
</table>

**Figure 7: Type of placement (public, private or combined)**

This table confirms that there is a higher demand for SOLS for both specialists and GP obstetricians from public health services compared to that from private practices and that this has been a consistent trend over the life of the program.

*Continued on next page*
Overview of Programs, Continued

Length of placement

The average length of placements over the life of the program has remained relatively consistent. There are a higher number of short placements (1-3 days) especially for specialists. It is difficult to know if this is due to demand from hosts for shorter placements or if the availability of locums is influencing this pattern and hosts are accepting shorter placements because that is all that is available.

GPALS overview

GPALS was administered by the Australian Society of Anaesthetists (ASA) up until 1 November 2010, at which time it was transferred to the Department for interim management.

There is an identified skills shortage in rural anaesthetics. An integral part of maintaining rural and remote access to anaesthetics is to sustain existing services through appropriate locum support.

The number of GPAs remained steady during the first half of the preceding decade. The 2009 National Minimum Data Set Report indicates the total number of non-specialist practitioners undertaking anaesthetics has fallen from 488 in 2008, to 438 in 2009. However, this number has remained relatively steady since 2002 when it was 456.

Of the total 438 known GP anaesthetic practitioners, 248 of these also undertake other procedures in either obstetrics and/or surgery.

During the early stages of scoping the feasibility of GPALS, the size of the pool of accredited GPAs was estimated to be 624, based on the number of GPA recipients who received a grant under the DoHA Training for Rural and Remote Procedural GPs Program (since then renamed to the Rural Procedural Grants Program (RPGP) during 2008–2009. This assumption has turned out to be incorrect as the RPGP does not require GPA participants to be accredited by the Joint Consultative Committee on Anaesthesia (JCCA) in order to participate in the program. Further enquiries have revealed that there is no data available to determine how many JCCA-accredited GPAs are currently practising in Australia.

According to the Australian Institute of Health and Welfare (AIHW) Labour Force Survey 2008, 3195 clinicians were working as specialist anaesthetists in Australia. However, the ASA note that there is a shortage of specialist anaesthetists in rural areas in relation to unfilled positions.

At the invitation of DoHA, the ASA undertook a study to determine the feasibility of establishing the GPALS program, based on the SOLS model. The review commenced on 8 August 2008 and was completed on 11 February 2009. The study found an overwhelming need for GPALS and recommended that DoHA fund the program at a rate of 100 locum days in year one and 200 in year two.

GPALS officially began on 8 September 2009 as an expansion of the SOLS model and its aims and objectives are in line with those of SOLS for specialist and GP obstetricians. That is, GPALS maintains and enhances the access of rural Australians to quality local GP anaesthetist care by providing the rural and remote GP anaesthetist workforce with efficient and cost-effective locum support. The program aims to sustain safety and quality in rural GP anaesthetist practice by facilitating access to personal leave for professional development or breaks from on-call commitments for rural and remote GP anaesthetists.

Continued on next page

---

6 ANZCA and ASA, March 2009, Australia’s looming Anaesthetist Shortage – New Study
Overview of Programs, Continued

**GPALS overview** (Continued)

As with SOLS, the program operates by providing host doctors with subsidised support to offset the cost of obtaining a locum. Unlike SOLS, however, GPALS provides support to GPAs through locums who can be either a GPA or a specialist anaesthetist.

Hosts are eligible for a maximum of 14 days of subsidised support per financial year, which can be taken as a block or a number of shorter placements. After this, hosts can use the GPALS program to connect with locums, but no further subsidies are offered. Priority is given to applications eligible for subsidised placements.

**GPALS Program outline**

GPALS provides subsidies for locum costs, travel time and travel costs. For the most recent funding period the subsidies offered are:

<table>
<thead>
<tr>
<th>Cost</th>
<th>Information</th>
<th>Subsidy (ex. GST)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum Subsidy</td>
<td>Subsidy per day for a maximum of 14 days per GPA per financial year</td>
<td>$750</td>
</tr>
<tr>
<td>Locum Travel Time</td>
<td>Maximum per placement</td>
<td>$750</td>
</tr>
<tr>
<td>Locum Travel Costs</td>
<td>Maximum per placement</td>
<td>$2000</td>
</tr>
</tbody>
</table>

**Figure 8: Schedule of Subsidy for GPALS**

Locum subsidies are approximately 50% of the current market rate for locums although locum charges can vary considerably. ASA did not charge an administration/application fee.

**GPALS Placements**

The ASA experienced difficulties in achieving uptake of GPALS. Initially the low numbers were thought to be a timing issue due to the program being launched in September when many of the rural anaesthetic workforce may have already arranged their locum relief. Despite this, the program continued to be challenged by the low uptake. The graph below demonstrates that actual placements and days have both fallen well below the program targets.

**Figure 9: GPALS Target and Actual Placements and Days**
Overview of Programs, Continued

Unsubsidised Placements

There were no wholly unsubsidised placements during the life of the program to date. However, there were 13 unsubsidised days where hosts requested locum relief beyond the 14 day limit on the subsidy.

Placement locations

<table>
<thead>
<tr>
<th>State</th>
<th>RA</th>
<th>Total no of days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vic</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>NSW</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>NSW</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>NSW</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>NSW</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>NSW</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>NSW</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>NSW</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>NSW</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>NSW</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>NSW</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>SA</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>SA</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>SA</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>SA</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>SA</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>NT</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>WA</td>
<td>4</td>
<td>21</td>
</tr>
</tbody>
</table>

Figure 10: GPALS Placement Locations

Of the 18 successful GPALS placements, there were only 10 separate locations. NSW and SA were the major users of the service.

Type of placement

During the GPALS operation, a total of 366 locum days were requested and 268 of those days were from public hospitals; however of these 268 days requested, only 57 days were able to be supplied.

Arrangement of locum

<table>
<thead>
<tr>
<th>No of successful placements</th>
<th>Locum arranged by host</th>
<th>Locum arranged by GPALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>8</td>
<td>6 (75%)</td>
</tr>
<tr>
<td>GP Practice</td>
<td>9</td>
<td>3 (33%)</td>
</tr>
</tbody>
</table>

Figure 11: Arrangement of locum

The above table demonstrates that of the small number of successful placements achieved by GPALS up to November 2010, only 8 of those locums were sourced and arranged by GPALS. The remaining number were found by the host and channelled through the program in order to access the subsidies.

Continued on next page
Overview of Programs, Continued

RGPLP overview

The RGPLP is a component of the Rural Health Workforce Strategy and also forms part of the NRLP. The program is designed to provide support to rural GPs and improve rural workforce retention through the provision of locum services and subsidies to rural GPs to assist in meeting locum costs.

RHWA was commissioned in late 2009 to administer the program nationally and has subcontracted its partner Rural Workforce Agencies (RWAs) in each state and the Northern Territory to deliver the scheme. The RWAs are:

• NSW Rural Doctors Network
• Health Workforce Queensland
• Health Recruitment Plus Tasmania
• Rural Doctors Workforce Agency South Australia
• Rural Health West Western Australia
• General Practice Network Northern Territory
• Rural Workforce Agency Victoria

This subcontracting arrangement between RHWA and the RWAs makes the administration of the RGPLP different to that of SOLS and GPALS which are directly administered by a national body.

RGPLP supports GPs working in rural and remote areas, defined as ASGC – RA 2 to 5. The program provides hosts with subsidised support to offset the cost of obtaining a locum. As with SOLS and GPALS, hosts are eligible for a maximum of 14 days of subsidised support per financial year, which can be taken as a block or a number of shorter placements. In addition, a further 14 unsubsidised days may be made available, subject to the availability of locums. Priority is given to subsidised locum placements.

Continued on next page
Overview of Programs, Continued

RGPLP Overview (Continued)

RHWA determines the allocation of targets for each of the RWAs from the total placements and subsidised days available. This determination involves more than an allocation per population base. It was recognised that it was important to allocate sufficient placements for the smaller states and the Northern Territory in order to provide an incentive to be involved in a national program. This determination based on allocation equity was also made more complex by the varying levels of assistance that is already provided by each state and territory government in accessing rural GP locums.

The states and Northern Territory are funded for the respective target placements plus 15% administration fee.

RGPLP Program outline

RGPLP provides subsidies for locum costs, travel time and travel costs. The subsidies offered are:

<table>
<thead>
<tr>
<th>Cost</th>
<th>Information</th>
<th>Subsidy (ex. GST)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum Subsidy</td>
<td>Subsidy per day per financial year, for a maximum of 14 days</td>
<td>$500</td>
</tr>
<tr>
<td>Locum Travel Time</td>
<td>Maximum per placement</td>
<td>$500</td>
</tr>
<tr>
<td>Locum Travel Costs</td>
<td>Maximum per placement</td>
<td>$2000</td>
</tr>
</tbody>
</table>

Figure 13: Summary of RGPLP subsidies

RGPLP Placements

As can be seen from the above data, the number of RGPLP locum placements is high with the 2010/11 target placements being exceeded by 68% in the first six months of the year. The average length of placement is 7.6 days which has allowed many more GPs to access locum relief under the program.

Continued on next page
The data shows relatively steady uptake of the program across all states with the exception of Queensland and Western Australia, which both dramatically increased in Year 2 of the program. This may be due to some RWAs offering shorter placements to hosts in an effort to spread the RGPLP further. The data also shows relatively low uptake in South Australia which is due to the substantial locum program already provided by the SA State Government. Tasmania also demonstrates uptake levels comparable to NSW and Victoria.

Figure 15: Placements and subsidised days per state/territory Nov 2009 – Jun 2010 (Yr1) and Jul 2010 – Dec 2010 (Yr 2)

Figure 16: Placements by RA category by state/territory Yr 1

Continued on next page
The above two graphs demonstrate placements by RA category by state/territory over the time periods of Yr 1 and 2. Overall, most placements occurred in RA 3 (42.9%), followed by RA 2 (30.6%).

The share of RA 5 placements has decreased from 17 (21.8%) in Yr 1 of the program to 11 (7.8%) in Yr 2.

Unsubsidised Placements
There have been no wholly unsubsidised placements during the program.

In Year 1, across the total placements:
- the average number of subsidised days per placement was 8.5
- the average range was 7.9 days in RA 2 to 9.7 days in RA 5

In Year 2, across the total placements:
- the average number of subsidised days per placement was 7.6
- the average range was 7.1 days in RA 3 to 9.6 days in RA 5

It is clear that the length of placement required by hosts is longer for RA 4 and 5.

<table>
<thead>
<tr>
<th>RA</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Total</th>
<th>% share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo Practice</td>
<td>15</td>
<td>32</td>
<td>9</td>
<td>7</td>
<td>63</td>
<td>25.51</td>
</tr>
<tr>
<td>Group practice</td>
<td>28</td>
<td>36</td>
<td>10</td>
<td>4</td>
<td>78</td>
<td>31.58</td>
</tr>
<tr>
<td>Hospital</td>
<td>14</td>
<td>28</td>
<td>4</td>
<td>4</td>
<td>50</td>
<td>20.24</td>
</tr>
<tr>
<td>After Hours</td>
<td>12</td>
<td>28</td>
<td>8</td>
<td>8</td>
<td>56</td>
<td>22.67</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>124</td>
<td>31</td>
<td>23</td>
<td>247</td>
<td>100</td>
</tr>
</tbody>
</table>

Figure 18: Type of Placement – Practice/Site* (July to Dec 2010)
*Some placements may include both a private and/or hospital and/or after hours placement

Of the total placements in the period July to December 2010, 63 or 45%, were for solo practices, enabling vital leave for the incumbent doctor. Due to the demand for the program being in excess of the funding available, the RWAs have been prioritising locum placements to solo GP practices, solo GP practice towns and towns with 3 GPs or less.
### Overview of Programs, Continued

#### Links with other programs

The RWAs provide support to the rural workforce in each state and territory (except ACT) and run a number of programs, including other locum programs with various funding sources. The RGPLP is just one of those programs. However, good linkages exist and there is flexibility for RWAs to utilise locums registered with other programs for the RGPLP.

#### Overall results

The success of SOLS, GPALS and RGPLP to date has been mixed.

SOLS has been relatively successful in terms of meeting performance targets and enjoys good support from stakeholders. In 2009–10 it achieved 75 specialist placements which exceeded their target of 60 and 29 GP obstetrician placements which exceeded their target of 20. In the same period it provided 434 specialist subsidised days from a target of 478 and 200 GP obstetricians subsidised days from a target of 280. It has been successful in building a good supply of locums (104 specialists and 53 GP obstetricians).

GPALS has not been successful in meeting performance targets. During its operation, GPALS provided just 18 placements from a target of 61, and 133 subsidised days from a target of 500. It was unable to attract a supply of locums with 24 registered with the program and only 7 providing actual locum relief. Demand for the program was also low with only 11 additional requests for placement received which were unable to be met.

RGPLP has been very successful in terms of meeting performance targets. In the six month period July to December 2010 it has provided 141 placements, exceeding its total year target of 84 placements. Across the same period, it has provided 1075 subsidised days, well on track to meeting the total year target of 1176 days. In the six month period, the 141 placements were completed by 95 locums. Of these, 56 locums were introduced to the respective RWA for the first time via the RGPLP placement.
Appropriateness of the NRLP

Feedback from both hosts and locums within the NRLP is strongly supportive of its continuation as an appropriate way to provide locum support. Additionally, nearly 200 respondents to the electronic survey conducted as part of this review agreed that the Australian Government should continue to provide support to enable locum relief to rural GPs (see Attachments 5, 6 & 7). They particularly noted the role of the NRLP in supporting rural clinicians to take personal and professional leave, to address the costs of locum relief and, as a consequence, to aid in retention of the rural medical workforce.

Respondents to the survey identified a range of personal benefits of using a locum service. Of most significance was the opportunity to obtain a break from work — to prevent burnout, spend time with family, and have a holiday:

• 'Finally able to get a holiday with the family, would not have lasted much longer without.'
• 'Ability to get away with family and have a break.'
• 'Provided much needed relief.'

Other benefits identified by respondents included:

• subsidised costs making a break more affordable
  • 'A break without huge financial cost.'
  • 'Access to the rebate to assist with expenses.'

• ability to reduce pressures of workload on themselves or colleagues
  • 'Sharing of workload.'
  • 'Helps colleagues cope in my absence.'
  • 'Don’t have a mountain of work on my return.'

• peace of mind while away
  • 'Ability to be able to leave town and not worry about practice and hospital.'
  • 'Peace of mind while on maternity leave.'

• the opportunity for education or professional development
  • 'Chance to get refreshed in education …'
  • 'Allowed me to travel to go to an overseas meeting.'

• continuity of service to patients
  • 'Ability to keep practice running while away.'
  • 'I didn’t have to shut up shop.'

SOLS

There has been strong stakeholder feedback on the continued need for SOLS. There are many case examples provided where, without the scheme, obstetricians would either not have taken leave or would have had to close services, resulting in women travelling considerable distances to access services. Given the reasonably good uptake of SOLS, the consequences of not continuing the scheme would be felt across up to one quarter of the rural medical obstetric workforce.

RANZCOG’s evaluation report of August 2009 notes that SOLS directly assisted in the prevention of transfer to a more distant medical centre for at least 224 rural women during the absence of their regular obstetrician, enabling rural women to remain close to family and community support.
**Appropriateness of the NRLP, Continued**

**Continuance of Australian Government support for the program (Continued)**

Based on transfer costs of between $4,000 and $5,000, this represented a health service saving of approximately $1,000,000. This does not take into account other economic costs such as those incurred by the women or their significant others, or the potential quality and safety gains of not having to travel whilst in the later stages of pregnancy or, in fact, in labour.

**GPALS**

The final report on GPALS from ASA noted that during the period of operation, GPALS locums undertook a total of 381 anaesthesia cases. Of these, 305 were elective anaesthesia, and 76 were emergency and obstetric-related anaesthesia. Due to the limited uptake of GPALS to date, there has not been strong stakeholder feedback on the continued need for GPALS as a program. When GPALS placements have taken place, there have certainly been benefits to the host in terms of enabling access to leave and subsidy relief and to the local rural community by providing continuity for local health services.

Overall, however, the consequences of not continuing the scheme would be small. These would largely relate to not meeting the expectations of those few who know about the scheme and intend to use it in the future. In addition there may be some reputational risk to the Department in appearing not to specifically support this sector of rural medicine.

**RGPLP**

The RGPLP has been successful in terms of uptake of the program, providing 141 placements in the July to December 2010 period and exceeding their whole year targets. While these placements constitute a very small percentage of the overall GP workforce in RA 2 to 5 locations (3.1%) to date, the program has the potential to increase its reach over time.

The benefits of providing affordable locum relief to GPs are not easily measured but it is known to be a factor in aiding rural workforce retention. Discontinuation of the program may impact on the retention of GPs in rural practice and possibly disrupt the provision of health services to rural communities.

**Demand for the NRLP**

**Demand for GPALS and SOLS**

Data from the Rural Procedural Grants Program show that 253 GPAs, 313 GP obstetricians, and 292 GPAs/GP obstetricians accessed grant money to support training in these procedural areas in 2009–2010. This is many more than the numbers that accessed SOLS and GPALS to take leave for the purpose of undertaking continuing professional development.

However, SOLS and GPALS were not established to meet all locum needs of rural GP obstetricians or anaesthetists — rather, to address the gap thought to exist in preventing some from taking much-needed leave. This gap has never been accurately quantified. Current target placements for both SOLS and GPALS (as a percentage of estimated eligible practitioners) are 24% for rural specialist obstetricians, 4.3% for GPs with obstetrics specialty and 10.3% for GPs with an anaesthetic speciality. These crude percentages of coverage would suggest that for both SOLS and GPALS the targets set are only addressing a small fraction of overall potential need.

---

Demand for the NRLP
(Continued)

Specialist Obstetricians

The demand for locum support for specialist obstetricians is strong and consistent. The highest demand is from RA 2 services with 71% of specialist placements since July 2009 occurring in this category.

The demand is stronger from the public sector with an average of 62% of all specialist placements occurring in hospitals. The demand for specialist placements has been stronger from Victoria over the life of the program, accounting for 35% of all placements.

GP Obstetricians

The demand for GP obstetrician locums is also growing steadily since the inception of the GP obstetrician component of the program in July 2008. There is a trend for more frequent placements of shorter duration.

As with the specialists, the demand for locums is stronger from the public sector with an average of 54% occurring wholly within public placements and a further 32% occurring in a combined public/private placement. Only 14% occurred wholly within private practice.

The demand for GP obstetricians has been stronger in RA 3 with 48% of placements since July 2009 occurring in this category. Demand was also strong in RA 2 with a total of 38% of placements.

The jurisdiction with the highest number of placements is Queensland, which accounts for 44% of all GP obstetrician placements since July 2008, followed by Victoria with 25% and South Australia with 7%. NSW accounted for only 6% of all GP obstetrician placements and there were none in Tasmania.

GP Anaesthetists

The feasibility study undertaken by the ASA indicated a need for this program. Despite this identified need, GPALS has fallen significantly short of the target placement days as of 31 December 2010 providing only 133 placement days out of 500 available. A further 227 days requested were unable to be met which still indicates demand for the program is relatively low.

GPALS data shows that demand for rural anaesthesia locums is predominantly from public hospitals and that during the life of the program under ASA, NSW and SA were the highest users of the program. Of the 18 successful placements, 9 were in RA 2 and 7 in RA 3.

Demand for proceduralists with multiple specialities

The unmet need for GP proceduralists with multiple specialties is even less clear. From the Medical Practice in Rural and Remote Australia: National Minimum Data Set 30 November 2009, it is known that at least 337 GPs have two or more specialties. None of the three programs within the NRLP cater well to this target group. Anecdotal feedback from stakeholders indicate that periods of leave for multi-proceduralists are managed as follows:

• by other GPs within the practice or community, as generally these proceduralists practise in larger towns

Continued on next page
by hospitals, as these procedures are primarily undertaken in hospitals therefore periods of leave are managed (particularly for surgical and anaesthetics specialties) through re-scheduling and the employment of specialty locums. It is rare that a GP with multiple procedural specialties would be replaced by a locum with the same skills. In most instances the obstetrics component of multi-disciplinary GP placement is prioritised for locum replacement.

The need to support GP proceduralists is important not only in order to provide appropriate health services close to home for the rural community. The diversity and challenge of procedural medicine is shown by research to be central to attraction and retention in rural practice, and evidence suggests a strong link between the cessation of procedural services and the decision to stay or leave rural practice altogether.9

There are many factors which influence the number of GP proceduralists available to practise in rural and remote communities; however the provision of support for the maintenance of work/life balance and to attend education through locum availability and financial subsidy are considered key issues.10

**Demand for RGPLP**

Similarly, the RGPLP provides support where other locum programs are unable to meet the need. Demand for the RGPLP is strong and will continue to grow as awareness of the program improves.

Clearly, an unmet need for the provision of GP locum services is emerging. Despite the various other subsidised locum schemes and the commercial agencies available, the demand for the RGPLP has been strong and 49 requests for placement remained unfilled largely due to the inability of the RWAs to supply a locum at the time or location requested. Other contributing factors leading to the unmet placements included hosts cancelling the placement or amending the placement dates.

According to the National Minimum Data Set 2009, the number of practitioners in RA 2 to 5 locations, excluding proceduralists, is 3697. This is potentially the number of GPs eligible for the RGPLP subsidy. Of the total number of practitioners, 556 or 12.1% are solo GP practices, which are arguably the population that will most benefit from this program. However it is important to note that over 462 of these solo GP practices are in RRMA 4 and 5 areas, so this does not necessarily mean that they are solo GP practice towns.

Currently, the RWAs prioritise the demand for the program to solo GP practices, solo practice towns and towns with 3 GPs or less. It is clear that a further prioritisation process will need to be considered in order to manage the demand for the program or consideration will need to be given to the expansion of the program.

---

9 Rural Workforce Agency Victoria, *Future of the GP Proceduralist Workforce, Submission to Health Workforce Australia* 2010.

In relation to the amount of leave that rural and remote GPs wish to take, the data set report indicates that, on average, GPs take approximately 4.5 weeks of leave per year compared to the average of 6.1 weeks of leave per year that they wish to take. There is a wide variation in this data with some GPs reporting they have taken as little as 0.5 week leave per year and others 10 weeks per year.

There are other factors to be taken into consideration in looking at leave data. Many of these GPs have significant ‘on call’ requirements with an average of 8.1 hours per week worked ‘on call’ and an average of 54.6 hours per week available ‘on call’. Again there is wide variation in these figures, with some GPs working 40 hours per week ‘on call’ and available up to 168 hours per week ‘on call’. It is reasonable to conclude that GPs working and available for significant periods of ‘on call’ would require more leave in order to maintain some work–life balance.

Another factor to be taken into consideration when determining priorities and appropriate leave levels is the workload of practitioners. For those GPs working full time it may be appropriate to prioritise locum support and/or to offer more leave. The data shows that 2724 or 77.3% of the GPs who provided information to the National Minimum Data Set 2009, self-reported working more than 35 hours per week. The average number of self reported GP hours worked (including travel, teaching, training and hospital hours) is 43.49 per week.

The NRLP provides for 14 days of subsidised leave relief per year. However, the average length of placement for the SOLS program (including subsidised and unsubsidised days) is approximately 9 days per placement. There is a tendency towards more frequent placements of shorter duration. Since July 2009, 69% of all placements for specialist obstetricians have been for 1–7 days due to the preference of hosts for shorter placements.

Similarly, the average placement duration for RGPLP is 8 days, despite the 14 days being available to hosts. However, it is known that some RWAs allow placements of shorter duration in order to spread the finite resources of the program more widely. Offering less than 14 days of subsidised leave may not be an appropriate strategy to try to manage demand, particularly in more remote locations. Hosts, particularly those from more remote communities, require an adequate block of leave in order to maximise the benefits of the leave period.

---

11 The Australian Bureau of Statistics defines full time work as 35 hours per week or more.
There are mixed views regarding the appropriateness of the NRLP subsidies being administered through the selected organisations.

Some stakeholders consulted during this review outside of RANZCOG, ASA and RHWA have noted that the structure of the schemes may restrict access to the subsidies. This is because of its availability only through SOLS, GPALS and RGPLP, despite the high number of locums being placed through other providers, including commercial locum schemes. This may become an issue if the NRLP schemes are unable to supply a locum and the host is forced to procure a locum through another source, and yet is unable to access the subsidy. It must be noted that all three programs will provide the subsidies if the host arranges the locum themselves and registers them with the NRLP schemes. So although this requirement does allow wider access to the subsidies, it does provide a barrier in that:

- hosts may not be aware they are able to refer their potential locum to the individual program so that they are able to access the subsidy
- it involves more paperwork for the potential locum in terms of registering with the NRLP scheme. The amount of paperwork required was a factor which was highlighted in the survey as a potential barrier for both hosts and locums

In 2009–10, SOLS was unable to fill 21 specialist and 11 GP obstetrician requests for placement. GPALS was unable to fill 11 requests during the life of the program and RGPLP could not fill 49 requests from eligible GPs during the period July to December 2010.

For SOLS and GPALS, this is largely due to the program’s inability to provide a suitable locum to fill a particular need at a particular time (such as a placement in a private practice requiring the locum to have private medical indemnity insurance). For RGPLP, access is more likely to be limited by its finite funding which, due to demand, resulted in the program being fully subscribed both in 2009-10 and 2010-11.

An alternative method should be considered to ensure that the subsidies are readily accessible to those hosts who have the greatest need for subsidised locum relief, regardless of how they source their locum.

In relation to RGPLP, the Communio survey found that there is some level of confusion among GPs as to what programs and levels of subsidies are available to them, and how to go about accessing these subsidies. There are many other locum service providers in the marketplace in addition to the RWAs (who themselves each run several different locum programs depending on the source of the funding). Other providers include commercial locum agencies and locums provided through Divisions of General Practice. There are also locums who are sourced through private arrangements and networks.

Stakeholders suggested that a more streamlined approach is required to simplify access to the subsidies for GPs.
There are also mixed views in relation to the appropriateness of the NRLP schemes as locum providers. RANZCOG, for example, has had reasonable levels of uptake and engagement amongst its members for SOLS, particularly specialist obstetricians. SOLS users note the increased comfort they have observed in using a locum system backed by their professional college, however in reality RANZCOG provides no additional vetting of quality to that of other locum providers.

There is a raft of Australian Government funded programs and subsidies available for rural and remote medical practitioners aimed at supporting workforce strategies or quality of practice. Knowing which initiative applies to whom requires considerable research, albeit through central information access points such as www.doctorconnect.gov.au

The NRLP has potentially increased fragmentation and market confusion in the already crowded medical workforce support environment with the introduction of three new schemes and two new administering agencies.

A Google search of Australian Medical Locum results in 109,000 listings and restricting that further to Australian Rural Medical Locum results in 14,000 listings. Australian Rural Anaesthetic Locum results in 55,000 listings. However, it should be noted that GPALS is the first listed. Similarly, a Google search of Australian Rural Obstetric Locum results in 426,000 listings, with SOLS as the first listed.

For potential locums, there are a number of benefits to using a private organisation rather than SOLS, GPALS or RGPLP. Many private organisations provide real-time online job listings with 24 hour consultants to help in arranging accommodation, travel, insurance and registration, and assist with completion of paperwork. Although it should be noted that the NRLP also provides assistance in these areas.

There appear to be fewer benefits for hosts in choosing private organisations. The most obvious drawback is that these organisations do not offer subsidies, so the cost of a hiring a locum is substantially higher. In addition, many private organisations charge hosts a percentage on top of total locum earnings.

Unless those arranging locums are clear about the specific advantages provided by the NRLP, then there would be no reason for them to search out these providers over and above the locum providers they may have used in the past.

The advantage of the NRLP being administered by the selected organisations is that, for SOLS at least, they are consolidating and building a supply of locums in what is a very small minority group in the overall scheme of locum supply. A fragmented supply of locums, particularly for rural GP obstetricians and anaesthetists, would mean that hosts may find it difficult to source an appropriately skilled locum from the multitude of locum providers in the market.

SOLS has proven that it has established a suitable supply of locums from which to draw and that it can mostly meet the requests from hosts.

GPALS has not managed to establish either sufficient demand from hosts or supply of locums to make the scheme viable. Given the GPALS experience, it is unlikely that any specialised locum scheme in the future will be able to improve on this due to the very small pool of potential locums. A different model should be considered for GPALS.

RGPLP has an adequate supply of locums, although this is mostly attributable to already established locum programs and locum supply in the RWAs. Increasing the supply of locums should be a focus of the program going forward.
Appropriateness of the NRLP, Continued

Over 80 respondents to the Communio survey expressed no preference or were unsure whether any locum service provider was better placed than any other to provide services.

Sixteen respondents (10%) nominated private agencies as their preferred choice for their flexibility and ability to negotiate remuneration rates on behalf of the locum.

Rural Workforce Agencies were also nominated by some as being best placed to ensure scarce allocation of resources goes where most needed.

The concept of a centralised agency had appeal for a further 5% of respondents:

- ‘It would be a lot easier for practices if there was one contact that can help with our locum needs rather than having a lot of different options and spending a lot of time dealing with multiple agencies.’

- ‘They should all be rolled into one service that can be contacted. Why have multiple services? Just duplication again. Very frustrating to get the run around all the time.’

Some respondents, however, noted the value of local knowledge:

- ‘Agencies that have good regional knowledge could provide a better service than one nationally based agency.’

- ‘There is a place for some centralisation, but local knowledge application of locums is essential to ensure a good alignment of locums and locations.

In summary, stakeholder feedback has indicated that the administering agency of a locum program should have a close relationship with the rural medical workforce and understand their needs. Bodies nominated as possessing these qualities include the RWAs, Divisions of General Practice, ACRRM and some commercial locum agencies.

Stakeholders also expressed the need for the administering agency to be able to tap into a supply of locums, but not necessarily own the locum supply. To effect this, a national approach is needed, with effective database management plus good relationships and networks between state and territory RWAs, Divisions of General Practice and medical colleges and associations.

Data provided from hosts, the administering bodies and private locum providers would suggest that the cost burden of sourcing a locum is indeed high. In addition to the direct costs of securing a locum (travel, accommodation, daily rates) the host also bears the costs of the locum’s usually reduced capacity to bill during their locum placement. This is a result of a combination of potentially reduced scope of practice and being an ‘unknown quantity’ in the local setting.

Additionally, if the locum is sourced through a commercial agency, the practitioner will also have to pay an agency fee, the current market rate of which is, on average, 15% of the locum fee.\(^\text{12}\)

Appropriateness of the NRLP, Continued

The subsidy for the NRLP is set at approximately half the market rate for the relevant locum type for up to 14 days per year. The subsidies were intended to provide a cost offset for hosts and were never intended to try to cover the full cost of employing a locum. Anecdotal evidence would also suggest that the market costs for locums are rising, particularly being driven by the impact of the so called ‘mining states’ which are paying a premium to ensure they have adequate medical cover in their mining towns.\(^\text{13}\)

Three quarters (75\%) of survey respondents identified the subsidy payment as being important or very important in using SOLS, GPALS or RGPLP and over 90\% rated the travel allowance as important.

Stakeholder feedback, including the survey found that there was recognition that the NRLP subsidies did not cover the entire costs to hosts of employing locum relief, but that the subsidies were nevertheless a welcome offset.

For all three programs, the amount of travel allowance for the locum was considered inadequate by stakeholders and an increase was recommended to cover the full amount of time taken to travel to and from the host location. This was particularly in relation to the more remote locations which require significant travel time.

Consultation has also revealed that the level of subsidy is of considerable less importance to hospitals than for private practitioners. The ability to access a locum is the primary incentive for hospitals to access the schemes whereas, for private practitioners, the availability of subsidies is of high importance.

In recognition of this, and in order to ensure the subsidies are delivered to the hosts who are most in need of the financial support, some stakeholders have suggested that consideration could be given to limiting access to subsidies to private practitioners only. Under this proposal, hospitals would be able to access locums through the scheme, but not the subsidies. This would enable the funds of the NRLP to be spread more widely across the GP sector.

The potential disadvantage to this model is mostly to SOLS, where 62\% of all specialist placements and 54\% of all GP obstetrician placements are within the public sector due to the high cost of private medical indemnity insurance required for private practice placements. Any disengagement of the hospital sector may affect the overall demand for the program and the supply of locums.

The appropriateness of capping the subsidies at 14 days was examined during this review. In the SOLS 2008-2009 Evaluation Report, it was noted that locations with more than one obstetrician generally underuse their eligible subsidised days as they can often access locum support from within their location. However, locations with only one obstetrician tended to use more than the 14 days support. This was particularly true for locations with only one GP obstetrician. This highlights the possibility that sole practitioners may require more subsidised days than those from larger practices or larger hospitals with multiple obstetricians.

The data for SOLS in 2009-10 showed 34 unsubsidised days in RA 4 and 5 locations which accounted for 18\% of all unsubsidised days. These were mostly for GP obstetrician locums. 2010-11 data shows only 2 unsubsidised days for GP obstetricians in RA 4 and 5 locations year to date. There is no discrete data available to identify locations with only one obstetrician.

\(^{13}\) Pers com, Dr Hamish Meldrum, Ochre Health July 2010.
Given there is no obvious trend towards a need for RA 4 and 5 locations to have more subsidy days available, it would be reasonable to leave SOLS Management Group to provide discretionary extended support on a case by case basis.

There were no calls to increase the number of subsidised days available per year for GPALS.

Some of the state-based subsidised GP locum programs provide up to 8 weeks of subsidised locum relief per year. The higher number of weeks is generally in recognition of the extensive ‘on call’ requirements of solo practice towns and GPs who provide VMO services to local hospitals.

Given the limited resources of the RGPLP to meet the demand, stakeholders consider that capping the subsidies on a sliding scale depending on the circumstances of the GP will provide more adequate support to those GPs most in need of subsidy assistance.

Targets have been set for the NRLP programs based on a range of factors including perceived need and available budget. Targets were set and agreed for both number of days and number of placements and have been renegotiated for SOLS and GPALS based on emerging trends.

During 2009-10, GPALS did not achieve the targets for placements and subsidised days, while SOLS exceeded placement targets, but did not meet the targets for subsidised days. SOLS is tracking well to meet its targets for 2010-11. RGPLP exceeded its target placements for 2010-11 in the first six months of the year and will certainly achieve its target number of days.

Whilst not formally set as an indicator, levels of satisfaction in the conduct of the programs have been high for all schemes (albeit on limited numbers for ASA).

Data suggests that SOLS is achieving approximately 25% of its specialist target group but less than 10% of GP obstetricians and 4.3% of all GPs with an obstetrics specialty (ie multi proceduralists). Therefore based on these crude figures, there is the potential for approximately 360 specialist placement requests per year and 260 GP obstetrician placement requests per year. However, given that SOLS is currently mostly meeting the demand and is steadily building a locum supply to meet that demand, there is no case to support any changes to target placements and days, however GP obstetricians in RA 4 and 5 locations (RRMA 6 and 7) should be particularly targeted as practitioners most in need of support.

It is difficult to quantify true demand for locum services for both GPA and specialist anaesthetists in rural and regional Australia. As many GPAs also carry a generalist GP load, it is unclear how many of these would require their anaesthetic component relieved as opposed to their generalist component, or both.

GPALS targets were set at 16 placements for 2009-10 and 45 placements for 2010-11. There is a total of 438 GPAs practising in RA 2 to 5. Of these, approximately 88 could be prioritised as solo GPA practices or in solo GPA towns, which should be the target group for subsidy and locum relief.

Therefore, the target of 45 placements for the period July 2010 to June 2011 appears reasonable yet the program fell well short of this. The challenge for GPALS in the future is to facilitate access to the program for those prioritised GPAs.
There are two aspects to be considered in relation to the appropriateness of the target placements and days for the RGPLP. Firstly, it assesses the appropriateness of overall targets set between DoHA and RHWA for the RGPLP and secondly it assesses the appropriateness of the targets for each state/territory as agreed between RHWA and the RWAs.

The initial targets set for placements and subsidised days for RGPLP appear reasonable for the early stages of a new program. RHWA has met these targets and it is clear that demand is increasing steadily as the program becomes more widely known. The RGPLP is at a critical point where a decision must be made either to expand the program with commensurate funding or maintain the current targets through more focused eligibility criteria.

The target placements and subsidised days subsequently set by RHWA for the RWAs have also been examined. It is appreciated that there was an initial need to allocate a base level of targets for each state and the Northern Territory in order to engage these areas in the program. However, for the next funding period it would be suggested that a more targeted approach be taken in order to ensure that the GPs most in need receive locum and subsidy relief. This will not necessarily be distributed equitably throughout the states and Territory as each of them have varying levels of:

- state government support and
- numbers of GPs who are solo or solo practice town, and
- rurality and remoteness.

All of these factors should be taken into consideration when determining targets for the RWAs in the future.

As stated previously, there are potentially 3697 GPs currently eligible for the RGPLP subsidy. In the six month period to 31 December 2010, RGPLP facilitated 141 placements. This equates to less than 4% of eligible GPs. Clearly, as awareness of the program grows there will need to be further prioritisation around access to the subsidies to ensure the GPs most in need of subsidy and locum support can access the scheme, or an increase in funding levels. The current method of prioritising solo GP practices, solo GP practice towns and those towns with three or less GPs for RGPLP is reasonable. Depending on funding available for the scheme, there may be a further need to exclude those in RA 2 locations unless they meet the above criteria and to exclude those who already access other locum subsidy relief. There are currently 2662 practitioners (including proceduralists) in RA 2.

Finally, it must also be noted that the NRLP is just one of a number of subsidised locum schemes available and there is no expectation that it must meet all the demand. Rather it should be available to assist hosts who are unable to access subsidised locum relief through other programs.
This review found that there were some particular issues in relation to program guidelines and criteria which impacted on GPALS.

**Host eligibility criteria**

In November 2010, ASA undertook a limited survey of rural and remote public hospitals across Australia to determine workforce trends in respect of demand for permanent staff and locums for both GPAs and specialist anaesthetists. The report found that one third of rural/remote hospitals report a high frequency of difficulty in meeting required staffing levels, for both GPAs and specialist anaesthetists. Overall, the geographical region that consistently experiences a high frequency of difficulty in locating anaesthesia staff is RA 3. As such, the demand for locums strongly relates to maintaining staffing levels as much as it might relate to relieving practitioners for purposes of professional and personal leave. The report concluded that in respect to temporary staffing, interchangeability exists for some positions between specialist anaesthetist and GPAs, which reinforces that there is a market for specialist anaesthetist locums in rural and remote hospitals.

Under the GPALS model, specialist anaesthetists are ineligible as hosts. However, a specialist anaesthetist can be used as a locum to provide anaesthetic services to a rural hospital if the doctor being replaced is a GPA.

The ASA have stated that increasing host eligibility to include specialist anaesthetists would increase equity of access to health care for rural communities by maintaining their access to local anaesthesia, obstetric and emergency services and that this would reduce costs associated with transfer of patients to regional hospitals.

**Locum Eligibility Criteria**

The current policy that a GPALS locum must be Joint Consultative Committee on Anaesthesia (JCCA) accredited, reduces the number of GPAs who can participate as locums. Although there is no data available to determine how many JCCA-accredited GPAs are currently practising in Australia, it is known that it is a very small number which also means that there is a very small pool of potential locums. In addition these potential locums are most likely located in rural areas, as the use of the GPAs in metropolitan areas is declining. These potential locums then are more likely to require locum relief than be able to supply it.

The ASA state that consideration should be given to expanding the locum eligibility criteria by basing it not on JCCA accreditation, but on the amount and type of clinical experience, which is measurable as all GPAs keep record books of all their anaesthesia related procedures.

**The Nomenclature “GPALS”**

The ASA maintain that the name GPALS is likely to reduce the participation of specialist anaesthetists in the scheme because they may not associate their professional identity with the name *GP Anaesthetist's Locum Service*. Additionally, the name ‘GPALS’ may also preclude hospitals from applying to the program as it may be seen as only providing a locum service for GPs and not hospitals.

---

14 *Rural Hospital and Anaesthesia Workforce Survey Report, November 2010, Australian Society of Anaesthetists*
For this reason the ASA recommends changing the name to Rural Anaesthesia Locum Service or similar so that it relates to rural anaesthesia more holistically and may increase the likelihood of gaining the attention of, and take up by, specialist anaesthetists and hospitals.

The administering bodies contribute towards the assessment and measurement of a range of objectives. Many of these are process-related. Other than the targets no numerical performance indicator is set. Given the qualitative nature of the issues this is appropriate.

It will be difficult to determine the overall impact of the NRLP in the absence of quality national workforce data. The current data sets do not allow for any tracking of leave taken or unmet demand with respect to leave. Data on total uptake for locum services is also unknown given that much activity occurs through the private sector. Retention data is also not available on an individual practitioner level so it is difficult to determine the impact on retention for any of the users of the NRLP programs.
Effectiveness of the NRLP

In order to provide a successful service, all three programs were required to establish an adequate locum supply as part of the overall aim to increase access to locum relief for rural hosts.

**SOLS**

SOLS has been effective in building locum supply with a total of 157 locums currently registered. Despite this, in the 2009-10 period, SOLS was unable to fill 32 requests for locum placements and the data is tracking for similar levels in the 2010-11 period. One of the issues which impacts upon locum supply relates to private medical indemnity insurance. Only about 30% of SOLS locums have private medical indemnity insurance, therefore restricting their access to public patients only. This subsequently reduces the number of locums available to fill placements in private practice. SOLS has recently negotiated a special rate with an insurance company for SOLS locums which may, depending on uptake from SOLS locums, improve locum supply to private practice.

Another area where SOLS has difficulty in providing a locum service is for GP proceduralists with more than one specialty. It is known that of the total of 583 GP obstetricians, 322 of these also undertake other procedures in either anaesthetics and/or surgery. It is unlikely that potential hosts seeking a locum for a GP with multiple specialties would initially look to SOLS to fill the vacancy.

**GPALS**

Overall GPALS has not been effective in improving locum supply. Of the 24 medical practitioners registered with GPALS for locum work, only 7 participated actively as a locum during the program.

The fundamental difference between SOLS and GPALS is that the SOLS model of providing subsidies to specialist obstetricians was not extended to GPALS, that is specialist anaesthetists are out of scope as hosts for the program. This difference was not considered to be a barrier during the GPALS feasibility study but was found to be a very significant barrier during ASA’s administration of the program. From the feasibility study it was anticipated that approximately 100 specialist anaesthetists would register as locums for GPALS. However, the anticipated participation in the scheme has not been borne out in registrations with only 4 practitioners with specialist qualifications registering with GPALS.

The ASA argue that expanding the GPALS scheme to cover specialists may increase the overall involvement of specialist anaesthetists in the program and may increased the likelihood of increasing locum supply. Conversely, however, potential locums who responded to the ASA survey in the feasibility study did not exhibit a strong desire to become a locum without an explicit requirement or inducement to do so. Therefore opening up GPALS to specialists may not necessarily increase the supply of locums, only the demand.

*Continued on next page*
Effectiveness of the NRLP, Continued

Additionally, increasing the supply of specialist locums may not necessarily meet the demand for GPA locums. There are a number of barriers to employing specialists in the GPA role. These include the following.

- Unlike SOLS, GPALS only offers one level of subsidy, so the cost to the host of employing a specialist locum could be much higher than a GPA locum. Although the ASA study found that rural hospitals were agreeable to employing specialist anaesthetists in place of GPAs it is unlikely that GPAs would employ specialist anaesthetists as locums due to the associated higher costs.

- There are difficulties in finding specialist anaesthetists who can match the clinical skills of the GPA and are prepared to undertake the GP component of the role. Additionally, the GPA may also be a multi-proceduralist who provides obstetric, surgical and emergency services.

The reality is that there may only ever be a small pool of GPA locums to draw from. The majority of GPAs work in the rural sector and are more likely to need locum relief than to be able to supply it.

Any strategy to increase locum supply must look to other sectors of the medical workforce to supply these locums. Options to increase locum supply include employing salaried locums with the skill set required, and expanding on the Rural LEAP model to include proceduralists such as anaesthetists.

RGPLP

RGPLP has had mixed success to date in relation to increasing locum supply, with some states and territories reporting success in registering new locums and others reporting minimal increased registration. Despite this, 56 new locums have been introduced as a result of the RGPLP in the second half of 2010.

The demand for the RGPLP has been strong. The 49 unfilled requests were largely due to the inability of the RWAs to supply a suitable locum at the time or location requested by the host. In other instances, the skills/needs of the locum and the needs of the host (on call, after hours, emergency skills etc) could not be matched, or the host had cancelled the placement or amended the placement dates.

One of the key success factors in the RWAs delivery of the program is that the RGPLP runs concurrently with other locum programs that the RWAs administer. This increases administrative efficiency and enables the efficient use of locums (often salaried) to interchange between the various locum programs.

The most important goal is that rural and remote GPs can access locum support, when they need it, at a reasonable cost. In the end, if this aim is achieved, how the locum is supplied is largely of little importance relative to the overall outcome achieved.

A key factor to be considered in the expansion of the RGPLP will be the continued availability of locums and strategies to address the locum supply. The overall supply of locum doctors needs to keep growing over time to match the strong demand from host GPs.

An overarching focus on locum supply is required without necessarily involving attachment of the locums to any one program. The Rural Locum Education Assistance Program (Rural LEAP) is an example of this strategy. Rural LEAP provides urban GPs with up to $6000 funding to access three days training in emergency medicine in exchange for four weeks of rural locum placement (ASGC-RA 2 to 5) within a two year period. A similar focus could be applied to the Rural Procedural Grants Program if the criteria were extended to allow practitioners from RA 1 locations to apply in return for a commitment to provide a rural locum placement.
Effectiveness in improving locum supply

Another strategy to increase the overall supply of locums in rural Australia could be to work with the specialty medical colleges to encourage/mandate Registrar placements in rural locations of highest need (particularly targeting GP Registrars in the third year of Fellowship of RACGP). It is known that nationally, Registrars comprise approximately 10.8% of the rural and remote medical workforce. This would require some negotiation in order to ensure the supervision requirements were met and review of the eligibility criteria for locums with RGPLP.

Stakeholders have suggested that providing incentives for potential locums to participate in the NRLP could also improve locum supply. Suggested strategies include:

- Subsidised travel for spouses/partners
- Subsidised professional development – this could be scaled so that it provides more incentive for:
  - remote locum placements or
  - longer locums placements or
  - more frequent locum placement per year.

Effectiveness in subsidising locum costs

The second aspect of the overall aim of providing locum relief to hosts when they need it and at a reasonable cost must be addressed.

It is critical that access to the subsidies is targeted and provided to those GPs most in need of subsidy and/or locum support.

SOLS is required to prioritise solo or small practices, however, given that the current demand is not exceeding the program targets it is unlikely that this prioritisation is required.

GPALS is required to provide placements on a ‘priority of needs basis’. Given the low demand for GPALS to date, a prioritisation process has not been required.

RGPLP is prioritising placements to solo GP practices, solo practice towns and towns with three or less GPs. Given the demand for RGPLP to date and the high likelihood that this demand will increase, further refinement of the eligibility criteria for RGPLP may be required in the future or an increase in funding levels for the program. Consultation has revealed that the availability of subsidies is of greater importance to private practitioners than to hospitals.

For these reasons, it can be argued that locum subsidies could be more effective and targeted if eligibility was limited to private practitioners. If this were the case, access to the subsidies should not be through specific locum providers but through the NRLP regardless of where the locum was sourced.
Effectiveness in achieving market penetration

Each of the three programs has undertaken an extensive marketing program. The survey undertaken as part of this review assessed the level of awareness of the NRLP.

The survey found that overall, a majority of respondents were aware of the existence of the three locum programs:

- SOLS (75.0% or 165/220 respondents)
- RGPLP (72.2% or 161/223 respondents)
- GPALS (62.0% or 132/213 respondents)

Similar proportions understood that the Australian Government funds SOLS, GPALS and RGPLP (76.5%) and that financial subsidies are available to offset the cost of locums through these programs (73.5%).

The three administering agencies are working together to learn from one another and share resources as appropriate. The creation of the NRLP web page (www.rurallocums.org.au) has created a single front end access point to web-based information for the programs.

A review of relevant web sites identified that there is inconsistent reference or links to the NRLP programs in other stakeholder websites, as tabled in Attachment 2.

Effectiveness in meeting program objectives

By funding three administering agencies and providing subsidies for locum placements including travel assistance, the NRLP has assisted rural doctors to obtain time for rest and professional development.

However, the level of allocated budget, the limited reach achieved by these programs, and the multi-factorial nature of leave would suggest that this model of implementing the NRLP has only partially met the program’s overall objective of ensuring rural doctors are able to obtain adequate time for rest and professional development.
Efficiency of the NRLP

Inputs/outputs

Reporting requirements to the Department of Health and Ageing have been streamlined and agreed over time with the administering bodies. None of the schemes reported these to be significant or onerous.

Administrative costs

There is a significant level of overhead cost being incurred with the scheme being administered by separate agencies. This is especially so for RGPLP, which has two layers of administration within its structure.

It is clear that SOLS is performing well and with total secretariat costs at 16% it is difficult to argue for any changes to the administrative structure of the program.

GPALS, on the other hand, has had unacceptably high administrative costs per placement. With low requests for placement and low locum numbers, it is difficult to argue that GPALS should continue to be administered by a separate organisation. Options for amalgamation with SOLS or RGPLP should be considered. Alternatively, the program could be discontinued altogether, however, it is recognised that there is a continuing need for anaesthetists to be available to support obstetricians in the surgical component of their work, which in turn benefits the rural community.

Secretariat expenses for RHWA, together with the administration fee for RWA totals administration expenses at 29.7% of the total budget for the funding period. It is acknowledged that the administrative costs for a new program are always higher in the initial set up phase and it is anticipated that the costs for the period 1 July 2010 to 30 June 2011 will be slightly lower at 26.7%.

Of the RHWA secretariat expenses for the current funding period, 20% is budgeted for marketing and promotion and website and database development. It is likely that these costs will be reduced in the next funding period now that much of the establishment of the program has been completed.

Clearly the efficiency of the program in terms of administration costs is affected by the two layers of administration in RHWA and the RWAs.

However, the value of an overarching coordinating body can be argued, particularly in the set up phase of a new national program such as the RGPLP. RHWA:

- has enabled the development of a national database of locums so that the RWAs have access to a larger supply of locums than just those registered with their agency
- has played an important role in delivering a national marketing program and developing program guidelines and materials
- as a national body can vary the target placements across the states and Northern Territory and can provide a more targeted approach to the areas of most need
- has developed a good platform for the RGPLP with which other locum programs and Government initiatives draw linkages
- has provided a means of networking and sharing information between the RWAs
- collates and reports on the national performance of the RGPLP.

The role of the RHWA in going forward must be evaluated and defined. It is now well positioned to play a more strategic role in improving locum supply overall and to better target the provision of locum and subsidy relief. However, there is a need to monitor the administrative costs of the RGPLP and to ensure the role of the RHWA continues to provide value to the program.

Continued on next page
### Efficiency of the NRLP, Continued

**Administrative costs (Continued)**

Clearly, there are opportunities to streamline the administrative structure of the NRLP and improve the overall efficiency of the program. Options to amalgamate some or all of the programs should be considered.
Summary of key findings

Key findings for SOLS

**Key successes of SOLS**

Overall, the SOLS program is a successful program. The program:

- is meeting steadily growing targets for placements and subsidised days
- has been successful in building a good supply of locums, especially for specialist obstetricians, which is a critical achievement
- has high levels of support from both hosts and locums
- is well known to its target stakeholders
- has efficient and effective management and administration processes, including an advisory committee who provided expert guidance to the development of SOLS
- is well supported by RANZCOG
- provides a service to all states and territories (except ACT) and has a national base of locums from which to draw locum relief
- provides a level of subsidies which is considered adequate to partially offset the cost to hosts
- has flexibility to provide placements and subsidies to services/practices most in need.

**Key areas for improvement for SOLS**

The key areas for improvement identified for the SOLS program are:

- SOLS in its current form does not cater well for proceduralists with more than one specialty. It is unlikely that potential hosts seeking a locum for a GP with multiple proceduralist skills would look to SOLS to fill the vacancy or indeed that SOLS could fill the vacancy.
- SOLS has difficulty at times providing locums who require their own private medical indemnity insurance as only approximately 30% of SOLS locums have their own insurance.
- The SOLS model in its current form does not provide easy access to the subsidies for hosts who are using commercial locum agencies or their own networks for locum relief.

*Continued on next page*
Summary of key findings, Continued

Key findings for GPALS

For the small number of hosts who accessed the scheme, GPALS provided an effective locum placement with a considerable cost offset.

GPALS has developed appropriate internal processes which were effective during the operation of the program, albeit limited.

Key areas for improvement for GPALS

Key areas which impacted on the success of the GPALS operation are:

- Misalignment of the model with the way GPAs and hospitals generally source and use anaesthetic locums and resulting in low demand. Specifically:
  - The hospital sector has established relationships with commercial agencies and often uses specialist anaesthetists to fill GPA positions. The availability of the subsidies is not a key incentive for hospitals — rather, the availability of locums is of more importance.
  - GPAs often use private networks to source locum services. Alternatively, they will often only source a locum for the GP component of their role and leave the anaesthetic component to their local hospital to source or manage.

- Inability to procure a sufficient locum supply.

- Lack of clarity in relation to the shortage of anaesthetists in rural Australia. The ASA state that the shortage relates mainly to filling permanent positions, rather than the ability to find temporary locum cover.

- Unsustainable administrative costs per placement due to low numbers.

- GPALS in its current form does not cater well for proceduralists with more than one specialty.

- GPALS cannot provide locums at short notice for urgent leave.

- GPALS in its current form does not provide easy access to subsidies for hosts who are using commercial locum agencies or private networks for locum relief.

Continued on next page
Summary of key findings, Continued

Key findings for RGPLP

Key successes for RGPLP

The RGPLP has been successful in terms of meeting its objectives. The program:

- has met the targets for placements for the July 2010 to June 2011 period within the first 6 months
- has almost met targeted subsidised days for the same period
- has been successful in building the supply of locums
- has high levels of support from both hosts and locums
- is well known to its target stakeholders given its short duration
- has effective management and administration processes
- provides a service to all states and the Northern Territory, and has a national base of locums from which to draw locum relief
- provides a level of subsidies which is considered adequate to partially offset the cost to hosts of employing locums, although some review of these subsidies is recommended
- has flexibility to provide placements and subsidies to service/practices most in need due to its concurrent operation with other subsidised locum programs.

Key areas for improvement for RGPLP

The RGPLP, would benefit from the following issues being addressed:

- the anticipated increasing demand for the program will need to be managed
- focus on strategies to improve locum supply through collaboration with the Department of Health and Ageing, RACGP and ACRRM
- the subsidy available for travel time is not considered adequate to appropriately compensate for locum travel time to remote areas
- the capping of subsidy days could be better tailored depending on the GP’s remoteness and other responsibilities (eg VMO duties)
- the method of allocation of targets to the RWAs by RHWA should ensure a more targeted approach to those GPs most in need of locum and/or subsidy support
- as with SOLS and GPALS, the RGPLP does not provide easy access to subsidies for those hosts who are using commercial agencies or their own private networks for locum relief
- RGPLP targets GPs and therefore does not focus on GP proceduralists. It is unlikely that potential hosts seeking a locum for a GP with multiple proceduralist skills would look to RGPLP to fill the vacancy.
Key findings for NRLP overall

Key successes of the NRLP

The literature scan undertaken as part of this review found the availability of practical support to assist rural doctors to access leave has been well established as necessary to help maintain a strong rural health workforce. The establishment of the NRLP has seen direct funding of the administering bodies who manage subsidy support for locum hosts to assist with the daily cost of the locum and subsidy/reimbursement for locums to assist in covering their travel costs and time. For those who have used these schemes this government funding is welcomed and well received.

All three programs have high levels of satisfaction from both hosts and locums.

This review has found that it is appropriate for the Government to provide support to rural doctors to enable access to leave in a manner that allows continuance of local quality health services. Benefits to the community have been well documented.

The subsidy levels were considered by most stakeholders to be adequate in offsetting some of the cost of employing a locum. The capping of 14 days per practitioner per year was also generally considered to be adequate.

Approximately 20 respondents to the survey affirmed the value of the National Rural Locum Program. Comments included:

- 'The system works very well. It has been seamless doing my first locum, very warmly received by the docs taking leave and all in the town.'
- 'They are a necessity for rural practices. We rely heavily on them so that our doctors can have regular much needed breaks without the community suffering.'
- 'Essential to continuing well being and care of doctors and patients alike.'
- 'Essential to keep rural practice viable and to provide services to rural communities.'
- 'A good initiative that needs development. Key is a lot of availability and reasonable cost. Locums rarely earn the same as the principal they replace.'

Key areas for improvement of NRLP

Although stakeholders have welcomed the NRLP, the review has raised questions as to whether a more efficient administrative structure would maximise the potential benefits of the program.

The appropriateness and efficiency of having separate administering bodies for these schemes has been questioned through this review. Whilst there is strong support for the backing of the professional colleges / associations by stakeholders there is no strong evidence that this is a significant benefit for either SOLS or GPALS. Similarly, the efficiency of the double layer of administration for the RGPLP has also been questioned and there are arguments both for and against the maintenance of the two layers.

Stakeholder feedback has indicated that the administering agency of a locum program should have a close relationship with the rural medical workforce and understand their needs. Bodies nominated as possessing these qualities include the RWAs, Divisions of General Practice, ACRRM and some commercial locum agencies. RANZCOG is also well regarded by SOLS stakeholders.

Continued on next page
Key findings for NRLP overall, Continued

Stakeholders also expressed the need for the administering agency to be able to ‘tap into’ a supply of locums, but not necessarily own the locum supply. To effect this, a national approach to locum supply is needed with effective database management plus good relationships and networks between state and territory RWAs, Divisions of General Practice and medical colleges and associations. Improved locum supply remains a key success factor in any future NRLP model.

The current model of the NRLP restricts access to the subsidies to only those locums registered through the individual programs. The review has found that this is not an effective way to ensure the provision of locum relief and/or subsidies to the practitioners most in need of support. Whilst one of the aims of the program is to build a supply of locums to provide relief to the rural medical workforce, it should not be necessary to attach the locum supply to any one program.

Given the demand for RGPLP to date and the high likelihood that this demand will increase, further refinement of the eligibility criteria for RGPLP may be required in the future or an increase in funding for the program.

None of the three NRLP programs cater well for proceduralists with multiple specialties. Due to the difficulties in matching skills for this group it is acknowledged that replacement for leave often requires two or more locum placements. A simple method that enables these GP proceduralists to access the subsidies is required, along with a targeted communication strategy to inform them of the availability of the subsidy.

The NRLP has had limited reach to date. SOLS has reached approximately 25% of its target specialist obstetrician workforce, but less than 10% of GP Obstetricians and 4.3% of all GPs with an obstetric speciality (ie multi-proceduralists). GPALS targets were set at 5.7% of GPAs, yet this was not achieved. RGPLP, has exceeded its targets, however, this reach is less than 4% of eligible GPs.

It is not clear how well the NRLP is meeting previously unmet demand for locum services. The aim of the program is to address the shortfall where other locum providers are unable to provide a locum service or other subsidised locum programs are unable to provide subsidies to target hosts. It was never intended that the NRLP would meet the needs of all rural and remote medical practitioners.

The extent of current workforce shortages also means that the NRLP is operating in a very dynamic environment. Until higher overall workforce levels are achieved, locum supply will remain tenuous. Whilst there are no mandated leave requirements for medical practitioners, leave will remain at the discretion of the individual practitioner. The use of locums will also remain discretionary as one of a number of ways to support leave.

Continued on next page
Survey respondents had a number of ideas for improvement in relation to the model:

- ‘An alternative model is to employ salaried locums rather than contractors.’
- ‘The RWAV program for training GPs to work in remote communities is absolutely fantastic. There should be more training programs designed to help urban GPs upskill to take on remote work.’

This included some support for centralisation of administration:

- ‘A one stop shop would be ideal where practices could find private/public locum agencies and thus be able to find locum services when needed.’
- ‘A national or federal locum agency managed and administered by a newly structured SOLS administration should be set up to operate a nationwide locum service ...’

The need for reduction of red tape was a particular concern:

- ‘Removing red tape. Each out of 6 locum placements I have done in last 12/12 required me to submit 20-40 pages application pack — such a waste!’
- ‘Give the subsidy direct to the practice.’
**Summary of key findings of NRLP overall**

**Key successes of NRLP**

The NRLP has achieved considerable success in a short time period. The program:

- Has provided significant benefits to rural and remote communities in terms of ensuring continuity of service provision
- Provides significant benefits to hosts in relation to providing locum relief for personal and professional leave
- Provides subsidies which are generally considered adequate to partially offset the cost of employing locum relief
- Enjoys high satisfaction from those who have used the program
- Has met targets and program objectives (SOLS and RGPLP)
- Has facilitated networking and sharing of information between the three component programs.

**Key areas for improvement**

The key areas for improvement of the NRLP are:

- Streamlining of the current administrative structure of the program
- Development of a national approach to improving locum supply
- Review of the model to provide enhanced access to the subsidies
- Improved and refined definition of the target GP population group for the program
- Improved focus on meeting the needs of proceduralists with multiple specialities
- Reduced administrative requirements for locums.

**Conclusion**

There is no doubt regarding the benefits of the support provided by the NRLP for rural clinicians which enables them to take recreational and professional leave, address the costs of locum relief, and aid in retention of the rural workforce.

Although it was never the intention of the NRLP to meet the needs of the entire rural medical workforce, the limited reach of the program to date means the impact of the NRLP on sustaining quality and safety in rural practice and aiding retention would most likely not be widespread.

There is no doubt that the NRLP has been a welcome initiative to those hosts who have used the program. This report has identified the key successes of the program to date and the key weaknesses or areas for improvement for consideration.
Reference List


ANZCA and ASA, March 2009, *Australia’s looming anaesthetist shortage – New Study*


## Attachment 1: Review consultations

Key identified stakeholders who were consulted, have included:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dianne Bennett</td>
<td>GPALS Program Coordinator, ASA</td>
<td>Face to face, email, telephone</td>
</tr>
<tr>
<td>Peter Lawrence</td>
<td>Executive Director, ASA</td>
<td>Face to face, email, telephone</td>
</tr>
<tr>
<td>Katie Juno</td>
<td>SOLS Coordinator, RANZCOG</td>
<td>Face to face, email, telephone</td>
</tr>
<tr>
<td>Kate Lording</td>
<td>SOLS Evaluation, RANZCOG</td>
<td>Face to face, email</td>
</tr>
<tr>
<td>Kate Hardiman, Margie Mahon, Kristy Rodwell and each of the program managers from the RWA of each state and territory</td>
<td>RHWA and each state and territory RWA</td>
<td>Face to face, telephone, email</td>
</tr>
<tr>
<td>Steve Sant</td>
<td>CEO, RDAA</td>
<td>Face to face</td>
</tr>
<tr>
<td>Dr. Hamish Meldrum</td>
<td>Ochre Health (Private Recruitment Agency)</td>
<td>Telephone</td>
</tr>
<tr>
<td>Dr. Charlie Nadin</td>
<td>GP Anaesthetist; Chair GPA Committee, ASA</td>
<td>Email</td>
</tr>
<tr>
<td>Dr. Sue Keating</td>
<td>Specialist Obstetrician, Hobart</td>
<td>Telephone</td>
</tr>
<tr>
<td>Dr. Charles Brooker</td>
<td>Specialist Anaesthetist, North Sydney</td>
<td>Face to face</td>
</tr>
<tr>
<td>Theresa Brandau-Stranks</td>
<td>Executive Officer, Continuing Professional Development Division, ANZCA</td>
<td>Face to face</td>
</tr>
<tr>
<td>Rural Workforce Programs Section, DOHA</td>
<td>DOHA</td>
<td>Face to face, email</td>
</tr>
<tr>
<td>James Flynn, Dr Kathy Kirkpatrick, Pauline Curtis</td>
<td>RACGP</td>
<td>Face to face, email and telephone</td>
</tr>
<tr>
<td>Valerie Jenkins</td>
<td>Manager, Fellowship Services RANZCOG</td>
<td>Face to face, email</td>
</tr>
<tr>
<td>Jenny Johnson</td>
<td>Executive Officer RDA of Queensland</td>
<td>Face to face</td>
</tr>
<tr>
<td>Rachel Yates</td>
<td>Director Policy, AGPN</td>
<td>Face to face</td>
</tr>
<tr>
<td>Raylene Pascoe, Kim Madison, Karen Ward</td>
<td>ACRRM</td>
<td>Face to face</td>
</tr>
<tr>
<td>Melissa Glogolia</td>
<td>SOLS Coordinator</td>
<td>Email</td>
</tr>
</tbody>
</table>

*Continued on next page*
A number of other stakeholders were scheduled for interviews but were called away and were unavailable at the allocated times:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lisa Studdert</td>
<td>General Manager, RAHC</td>
</tr>
<tr>
<td>Dr. Frank Clark</td>
<td>Specialist Obstetrician, Launceston</td>
</tr>
<tr>
<td>Dr. Frank Maloney</td>
<td>Specialist Anaesthetist, Chair of Joint Consultative Committee on Anaesthesia (JCCA)</td>
</tr>
<tr>
<td>Dr Bruce Chater</td>
<td>Chair of Rural Grants Procedural Grants Collaboration Program, ACRRM</td>
</tr>
</tbody>
</table>
Attachment 2: Visibility of NRLP on Relevant Websites

Visibility

A range of web sites were viewed to determine the visibility of the NRLP on relevant websites.\(^\text{16}\) Some web sites had members areas that were not accessed. Others had information or reference to these programs contained in newsletters on the website.

<table>
<thead>
<tr>
<th>Visibility</th>
<th>RGPLP</th>
<th>SOLS</th>
<th>GPALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSWRDN <a href="http://www.nswrdn.com.au">www.nswrdn.com.au</a></td>
<td>+</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>RACGP <a href="http://www.racgp.org.au">www.racgp.org.au</a></td>
<td>+</td>
<td>Single newsletter</td>
<td>Single newsletter</td>
</tr>
<tr>
<td>RDAA <a href="http://www.rdaa.com.au">www.rdaa.com.au</a></td>
<td>-</td>
<td>+</td>
<td>Web link error page</td>
</tr>
<tr>
<td>ACRRM <a href="http://www.acrrm.org.au">www.acrrm.org.au</a></td>
<td>+</td>
<td>-</td>
<td>Single newsletter</td>
</tr>
<tr>
<td>ANZCA <a href="http://www.anzca.edu.au">www.anzca.edu.au</a></td>
<td>na</td>
<td>na</td>
<td>-</td>
</tr>
<tr>
<td>AGPN <a href="http://www.agpn.com.au">www.agpn.com.au</a></td>
<td>na</td>
<td>na</td>
<td>+ newsletter</td>
</tr>
<tr>
<td>RDAV <a href="http://www.rdaav.com.au">www.rdaav.com.au</a></td>
<td></td>
<td></td>
<td>Not visible in non-members area</td>
</tr>
<tr>
<td>RDAQ <a href="http://www.rdaq.com.au">www.rdaq.com.au</a></td>
<td></td>
<td></td>
<td>Not visible in non-members area</td>
</tr>
<tr>
<td>Health Recruitment Plus (Tasmania) <a href="http://www.healthrecruitmentplus.com.au">www.healthrecruitmentplus.com.au</a></td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>RHWASA <a href="http://www.ruraldoc.com.au">www.ruraldoc.com.au</a></td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>RWAV <a href="http://www.rwav.com.au">www.rwav.com.au</a></td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Health Workforce QLD <a href="http://www.healthworkforce.com.au">www.healthworkforce.com.au</a></td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Rural Health West <a href="http://www.rualhealthwest.com.au">www.rualhealthwest.com.au</a></td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>General Practice Network NT <a href="http://www.gpnnt.org.au">www.gpnnt.org.au</a></td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Rural Locums

A new website was launched in June 2010 as a joint venture between the three NRLP programs. The website www.rurallocums.com.au allows stakeholders to access information relevant to all three programs through the one front end portal. Depending on the stakeholders’ needs they are then directed to the relevant program website.

\(^{16}\) + indicates that a link or obvious information about the program was available
- indicates there was no easily identifiable information.
Attachment 3: Results of literature scan

Introduction

This literature scan provides a brief overview of a number of key issues related to supporting rural medical practice. Specifically, it addresses:

- current strategies being employed internationally to support rural medical practice
- strategies employed to increase locum supply internationally and within Australia, including government subsidisation of rural locum services
- characteristics of rural medical locum services that are considered to be important.

Background

The inequitable distribution of health workers in rural and remote areas is a global issue of relevance to both developed and developing countries. Approximately one half of the world’s population lives in rural areas, yet these people are served by only 24% of the world’s physicians (WHO, 2009).

This situation is more acute in some countries than others. In South Africa, for example, 46% of the population live in rural areas, while only 12% of doctors work there (Hamilton and Yau, 2004). In the United States, 20% of the population live in rural areas, while only 9% of registered physicians practice in these areas (WHO, 2010). In Canada, 2006 figures revealed that 24% of the population in lived in rural areas, with only 9.3% of the physician workforce represented (WHO, 2009).

In Australia, rural medical workforce issues are also a major health planning issue. In 1995, 27.7% of the Australian population lived in rural and remote areas, whereas 20% of primary care practitioners were located in these regions. The majority of these doctors were living and working in small coastal towns, making the scarcity of medical practice far more significant in the more remote regions of Queensland and Western Australia (AMWAC, 1996).

While the actual number of doctors practising in rural and remote areas of Australia has increased in the last decade, the number of doctors practising in metropolitan areas has also increased. Consequently the proportion of doctors in rural practice compared to urban practice remains essentially the same (National Health Performance Committee, 2004).

Various strategies have been employed both internationally and in Australia to develop a more equitable balance of medical service provision. Many of these strategies are only now being evaluated, and some have not been in place long enough to show a significant impact.

One strategy aimed at supporting practitioners in rural locations is the establishment of programs to provide locum tenens or locums. These programs have been highly praised by those they serve. However, they have their own inherent challenges and barriers that impede their effectiveness. The most significant of these appears to be sufficient supply of general practice locums.

Some of the strategies identified in Australia and internationally to address this and other challenges are discussed below.

Continued on next page
International context

Introduction

As discussed above, the inequitable distribution of health workers in rural and remote areas is more acute in some countries than others.

Given its status as a global issue, attraction and retention of doctors to rural and remote regions has been a focus of study and intervention internationally as well as in Australia. The World Health Organisation noted that strategies employed to address this situation essentially focus on two interwoven aspects of the issue:

- the factors that influence individual choice to both move to rural areas and to leave them
- the extent to which health systems respond to those factors (WHO, 2009).

International strategies

Interventions designed to encourage health professionals to choose to move to rural areas have been categorised by the World Health Organisation into three domains:

- education
- financial incentives
- management support programs.

Education interventions

Education interventions include targeted admission of students from rural backgrounds, recruitment from and training in rural areas, specific training in rural medicine and compulsory service requirements. This latter strategy has been highly successful in Japan, for example, where Jichi Medical University runs a bonded rural service program whereby tuition fees are waived in return for up to six years of rural service. As a result of this program, the number of rural communities without access to at least one medical practitioner has been reduced by 73% (Matsumoto, et.al., 2002).

Financial incentives

Financial incentives for rural service are also offered in many countries and include higher salaries for rural practice, access to loans for housing and vehicles, and access to special grants (WHO, 2009).

While financial incentives have been seen to be important, they are not necessarily found to be the most important factor in attracting and retaining doctors to rural practice. In addition to financial incentives, other management strategies are employed to provide support to doctors living and working in rural areas. These include improved living conditions, support for professional development opportunities and the provision of locum services to release individuals for holidays and further training. The Jichi Medical University for example, runs a locum service to supplement the bonded rural workforce described above (Inoue et.al., 2002).

Continued on next page
Management support programs
The provision of locum services to support rural practice is one of the most successful strategies used globally. In addition to the Japanese example already discussed, the British Columbia Medical Association has a longstanding rural locum program and has increased the financial benefits for locums in the most remote regions to ensure continued supply (British Columbia Medical Association, 2009). The University of New Mexico Health Sciences Center and the East Carolina University School of Medicine also provide locum tenens services for practitioners in rural and underserviced regions (Association of American Medical Colleges, 1999). Available evidence suggests that all of these Programs have been widely utilised and are considered highly effective by the practitioners using them.

While different operational structures appear to work in different environments, the common variable for an effective rural locum program appears to be adequate funding and institutional support.

Benefits of locum availability
Common beneficial outcomes of rural locum programs globally include:
• coverage for practitioners unable to pay for practice support in busy times
• coverage during vacations or while attending further education
• training in rural practice for the locums
• recruitment of physicians to rural practice sites (Inoue et.al., 2002; Association of American Medical Colleges, 1999).

Factors impacting on locum availability
While it is generally agreed that the provision of locum services to rural practice in some form is a highly effective strategy in retaining permanent practitioners in these areas, one of the major challenges — as identified above — is in providing consistent supply of locums.

International studies have explored the reasons why medical graduates choose to enter locum activity, and why they choose to leave. A study carried out by the University of Calgary and the University of Alberta between 2001 and 2005 found that the average period of locum practice was nine months. The main reason given by graduates for taking on the work was the pursuit of varied experiences, while the main reason for leaving this type of work was the desire to settle into a permanent practice. The positive outcome highlighted by this study is that 45% of the participants joined practices where they had done locum work, and so contributed to the permanent rural medical workforce (Myhre and Konkin et.al., 2010).
The Australian context

Introduction

The rural medical workforce remains a major challenge for policy makers in Australia. In 1995, the Australian Medical Association (AMA) identified the challenge of attracting and retaining an adequate supply of medical practitioners to rural and remote Australia as the single most important medical workforce issue (AMA, 1995). The challenge remains current in 2011.

The problem is particularly acute in very remote areas of Australia which have the highest proportion of health staff vacancies, including physicians, in the country (National Health Performance Committee, 2004). This is accentuated by the fact that the majority of the population in these very remote areas are Aboriginal Australians who also suffer the highest disease rates and have the greatest need of medical care.

Bukyx et al (2010) note a range of factors contributing to the rural medical workforce shortage in Australia, including:

• inadequate workforce policies guiding the number of doctors in training
• changing patterns of employment of doctors as new graduates seek better work-life balance
• more female doctors in medical training
• rationalisation of rural health services and changes in the nature of rural practice
• increased doctor mobility and decline in hours worked.

Other factors identified as disincentives to rural medical practice include lack of exposure to the rural lifestyle; limited exposure in medical schools to rural medicine; fear of professional isolation; lack of access to continuing education opportunities and a greater workload with less opportunities for time off (AMWAC, 1996).

Rural and remote GPs in Australia are usually required to manage a wide range of complex cases with limited access to specialist services for referral. As a result rural GPs often work longer hours and require a broader range of skills than urban doctors (Britt et.al., 1993). McGrail et al (2010) note that this aspect of rural practice is often the basis of negative ‘marketing’ with ‘many reports and research studies highlighting overworked, under-remunerated and undervalued rural doctors struggling to deal with sicker patients in communities characterised by chronic workforce shortages’.

Government strategies addressing attraction and retention, continued

The costs of poor workforce retention and high turnover are significant, including restricted community access to appropriate care and loss of skills and experience, compromising continuity and quality of care and resulting in high recruitment costs (Humphreys et al, 2009).

Australian Commonwealth and state governments have introduced a range of recruitment strategies and retention incentives over the past two decades to encourage more permanent doctors in rural general practice. These initiatives reflect global programs and include the provision of equipment, opportunities for continuing education, training and remote area grants, relocation assistance and locum support (Holub and Williams, 1996).
Specific examples include programs such as:

- the General Practice Rural Incentives Program
- Scaling of rural workforce programs, such as the Medical Rural Bonded Scholarship Scheme, the Bonded Medical Places Scheme and the HECS Reimbursement Scheme
- Rural Procedural Grants Program.

In their recent review of the effectiveness of retention incentives for health workers in rural and remote areas, Bukyx et al (2010) note that there is little evidence so far to show the effectiveness of any single retention strategy in making a significant difference to the medical workforce supply in underserved areas. They point out that, although provision of a financial incentive is the most commonly implemented retention strategy, evidence suggests that non financial incentives related to working and housing conditions have greater potential to influence decision-making about length of stay than financial considerations. This is consistent with the view of Humphreys et al (2002) who noted, some years previously, that factors affecting retention and turnover fall into three broad categories: professional issues, social factors relating to personal characteristics and the family, and external factors relating to the community and its geographical location.

For this reason, Bukyx et al (2010) propose a framework that ‘bundles’ retention incentives, identifying six key components that should be included in any comprehensive retention strategy. These are:

- maintaining adequate and stable staffing
- providing appropriate and adequate infrastructure
- maintaining realistic and competitive remuneration
- fostering an effective and sustainable workplace organisation
- shaping a professional environment that recognises and rewards individuals making a significant contribution to patient care
- ensuring social, family and community support.

Humphreys et al (2009) provide a number of examples of ‘bundled’ retention strategies, including:

- A hospital in rural Victoria trying to attract and retain psychiatrists reorganised workloads, altered rostering to better meet the needs of staff, and introduced an orientation program incorporating cultural training for international medical graduates.
- The establishment of a network of university-linked family practices in South Australia. Retention strategies aimed at professional development included support for higher degrees, conference attendance and teaching commitments, and sessional and academic appointments. The network also attempted to overcome organisational barriers to retention by providing infrastructure support for general and ICT facilities; while leave and locum support were also incorporated into the program.

At the same time, however, Bukyx et al (2010) note that there is evidence to show that financial incentives might assist with short-term recruitment and retention. This finding may have implications for locum relief strategies.
The Australian context, continued

Government strategies addressing rural locum availability

As discussed above in the international context, the availability of locum relief supports the retention of the rural workforce in a range of ways.

The Rural Health Workforce Strategy, as a result of the Rural Health Reform – Supporting Communities with Workforce Shortages budget measure, has seen a number of strategies introduced to strengthen rural workforce support through locum relief. These have included increasing the level of funding and reach for the National Rural Locum Program (NRLP). The NRLP comprises:

- **Specialist Obstetrics Locum Scheme (SOLS)**
  The aim of the SOLS program is to maintain and improve the access of rural women to quality local obstetric care by providing the rural and remote obstetric workforce (both specialist and GP obstetrician) with efficient and cost-effective locum support. The program aims to sustain safety and quality in rural practice by facilitating access to personal leave, professional development or breaks from on-call commitments.

- **General Practice Anaesthetist Locum Program (GPALS)**
  The aim of GPALS is to maintain and enhance the access of rural Australians to quality local GP anaesthetist care by providing the rural and remote GP anaesthetist workforce with efficient and cost-effective locum support. The program aims to sustain safety and quality in rural GP anaesthetist practice by facilitating access to personal leave for professional development or breaks from on-call commitments for rural and remote GP anaesthetists.

- **Rural General Practitioner Locum Program (RGPLP)**
  The RGPLP is designed to provide support to rural GPs and improve rural workforce retention through the provision of locum services and subsidies to rural GPs to assist in meeting locum costs.

Characteristics of rural medical locum services that are considered to be important

The literature is clear that a locum-based strategy alone is not a sustainable long-term solution to address the challenges of rural health workforce attraction and retention (Humphreys et al 2009).

However, locum relief is recognised nationally and internally as an important component of a broader approach and set of strategies. Some of the factors identified as important in the provision of effective rural locum relief include:

- program guidelines that enable doctors to spend a ‘reasonable’ amount of time away from the practice (Humphreys et al 2002) for personal and professional rejuvenation
- program guidelines that support attractive financial incentives for short term recruitment and retention (Bukyx et al 2010)
- the possible development of regional medical practice models in appropriate rural settings so that the facility to cover after-hours and relieve pressure is built into the local practice staffing and organisation arrangements (Humphreys et al 2002)
- increasing the exposure of, particularly, new graduates to the rural lifestyle. Mills (1997) notes in his description of one community’s experience of recruiting a general practitioner: ‘Maybe new graduates could work with the resident GP in rural areas and be available to locum for him or her for short periods of time’
- promoting the ability to enjoy new and varied professional and personal experience (Myhre and Konkin et.al., 2010).

Continued on next page
The Australian context, continued

Factors impacting on locum availability

Factors impacting on locum availability in Australia reflect similar issues internationally.

Disincentives to rural medical practice include lack of exposure to the rural lifestyle; limited exposure in medical schools to rural medicine; fear of professional isolation; lack of access to continuing education opportunities and a greater workload with less opportunities for time off (AMWAC, 1996). Rural and remote GPs in Australia are usually required to manage a wide range of complex cases with limited access to specialist services for referral. As a result rural GPs often work long hours and require a broader range of skills than urban doctors (Britt et.al., 1993).

Attractions in rural practice have been reported to include variety of practice, lifestyle and the ability to provide continuity of care (Gill et.al., 1992; Strausser, 1992).

Many of these initiatives have not been evaluated and for some initiatives, such as recruitment of rural students into medical schools and increasing the curriculum time allocated to rural medicine, it will be another decade before the real implications can be properly assessed.

Conclusion

Current evidence appears to indicate that the provision of locums to rural practice is a well utilised and well received initiative. However, the direct impact this initiative has on retention of rural doctors remains unmeasured.

It seems apparent that the full range of strategies demonstrated in various countries globally is necessary to establish rural practice as a viable option for new medical graduates and to retain these rural doctors long term.
References


Association of American Medical Colleges, 1999. ‘Academic models for practice relief, recruitment and retention at the University of New Mexico Center and East Carolina University School of Medicine’, Acad.Med.1999, Jan; 74 (Suppl) 139-40.


Humphreys, John S., Michael P. Jones, Judith A. Jones and Paul R. Mara, 2002. ‘Workforce retention in rural and remote Australia: determining the factors that influence length of practice’, MJA 176 (20), May.


Continued on next page
References, Continued


Strausser, Roger, 1992. ‘How can we attract more doctors to the country?’ Australian Journal of Rural Health. 1:39-44.

Attachment 4: Demographics of the rural medical workforce

GP Shortages

According to the Medical Practice in Rural and Remote Australia: National Minimum Data Set 30 November 2009, the number of medical practitioners practising in RRMA 4 to 7 locations has been steadily increasing since 2002 (see Figure 2).

Rural and remote communities generally have a relatively low ratio of GPs proportional to their population. National figures for GPs Full Time Equivalent (FTE) per 100,000 population across different geographic areas are as follows: 17

<table>
<thead>
<tr>
<th>ASGC Classification</th>
<th>FTE GPs per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major cities</td>
<td>97.0</td>
</tr>
<tr>
<td>Inner regional</td>
<td>83.1</td>
</tr>
<tr>
<td>Outer regional</td>
<td>74.2</td>
</tr>
<tr>
<td>Remote</td>
<td>68.2</td>
</tr>
<tr>
<td>Very remote</td>
<td>47.1</td>
</tr>
</tbody>
</table>

Figure 19: GPs Full Time Equivalent (FTE) per 100,000 population

Overall numbers of practitioners working in RRMA 4 -7 locations (now ASGC-RA 2 to 5) has been steadily increasing since 2002 and as at 30 November 2009 there were 4753 which represents and increase of 71 practitioners from the previous year.

Trends of change November 2002 to November 2009

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total practitioners</td>
<td>3903</td>
<td>4047</td>
<td>4186</td>
<td>4317</td>
<td>4345</td>
<td>4482</td>
<td>4682</td>
<td>4753</td>
</tr>
<tr>
<td>Percent female</td>
<td>28.4%</td>
<td>29.7%</td>
<td>30.0%</td>
<td>30.5%</td>
<td>32.2%</td>
<td>33.0%</td>
<td>33.2%</td>
<td>33.2%</td>
</tr>
<tr>
<td>Percent male</td>
<td>71.6%</td>
<td>70.3%</td>
<td>70.3%</td>
<td>69.5%</td>
<td>67.8%</td>
<td>67.0%</td>
<td>66.8%</td>
<td>66.8%</td>
</tr>
<tr>
<td>Average age female</td>
<td>42.19</td>
<td>42.6%</td>
<td>43.4%</td>
<td>43.9%</td>
<td>44.3%</td>
<td>44.7%</td>
<td>45.0%</td>
<td>45.0%</td>
</tr>
<tr>
<td>Average age male</td>
<td>47.72</td>
<td>48.01</td>
<td>48.6%</td>
<td>49.0%</td>
<td>49.2%</td>
<td>49.5%</td>
<td>49.7%</td>
<td>50.5%</td>
</tr>
<tr>
<td>Average age (all)</td>
<td>46.65</td>
<td>46.46</td>
<td>47.1%</td>
<td>47.5%</td>
<td>47.7%</td>
<td>48.0%</td>
<td>48.2%</td>
<td>49.0%</td>
</tr>
<tr>
<td>Average GP clinical hours</td>
<td>37.67</td>
<td>37.08</td>
<td>36.54</td>
<td>36.2%</td>
<td>36.7%</td>
<td>36.1%</td>
<td>35.9%</td>
<td>35.7%</td>
</tr>
<tr>
<td>Average total hours</td>
<td>46.65</td>
<td>46.65</td>
<td>43.68</td>
<td>43.68</td>
<td>44.4%</td>
<td>43.7%</td>
<td>43.9%</td>
<td>43.9%</td>
</tr>
<tr>
<td>Average length of stay in current practice (years)</td>
<td>8.29</td>
<td>9.15</td>
<td>8.25</td>
<td>8.1</td>
<td>8.27</td>
<td>8.2</td>
<td>8.17</td>
<td>8.38</td>
</tr>
<tr>
<td>*Proceduralists General Anaesthetics</td>
<td>456</td>
<td>435</td>
<td>459</td>
<td>463</td>
<td>445</td>
<td>431</td>
<td>488</td>
<td>438</td>
</tr>
<tr>
<td>*Proceduralists Obstetrics (Normal delivery)</td>
<td>706</td>
<td>638</td>
<td>657</td>
<td>661</td>
<td>622</td>
<td>599</td>
<td>623</td>
<td>583</td>
</tr>
<tr>
<td>*Proceduralists Operative surgery</td>
<td>287</td>
<td>287</td>
<td>304</td>
<td>283</td>
<td>275</td>
<td>268</td>
<td>282</td>
<td>258</td>
</tr>
<tr>
<td>*Known Proceduralists (practising in at least one procedural field)</td>
<td>935</td>
<td>902</td>
<td>933</td>
<td>929</td>
<td>907</td>
<td>896</td>
<td>934</td>
<td>862</td>
</tr>
<tr>
<td>*Proportion of rural practitioners providing procedural services</td>
<td>24.0%</td>
<td>22.1%</td>
<td>22.3%</td>
<td>21.5%</td>
<td>20.9%</td>
<td>20.0%</td>
<td>19.9%</td>
<td>18.1%</td>
</tr>
<tr>
<td>Proportion of practitioners providing emergency care services</td>
<td>41.7%</td>
<td>46.6%</td>
<td>46.35</td>
<td>41.4%</td>
<td>49.5%</td>
<td>48.5%</td>
<td>49.1%</td>
<td>44.9%</td>
</tr>
<tr>
<td>Proportion of practitioners providing Aboriginal health services</td>
<td>20.5%</td>
<td>22.8%</td>
<td>19.0%</td>
<td>21.4%</td>
<td>23.6%</td>
<td>23.7%</td>
<td>23.0%</td>
<td>23.5%</td>
</tr>
<tr>
<td>Proportion of GPs working in solo practices</td>
<td>16.6%</td>
<td>15.8%</td>
<td>15.7%</td>
<td>14.5%</td>
<td>14.6%</td>
<td>12.7%</td>
<td>13.1%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Proportion of GPs working in group practices</td>
<td>83.4%</td>
<td>84.2%</td>
<td>84.3%</td>
<td>85.5%</td>
<td>85.4%</td>
<td>87.3%</td>
<td>86.9%</td>
<td>87.9%</td>
</tr>
</tbody>
</table>

Figure 20: Trends or changes to in medical practice and rural and remote Australia

Continued on next page

17 RDAA Factsheet 1/2010 The medical workforce shortage in rural and remote Australia: The Facts
18 Medical Practice in Rural and Remote Australia: National Minimum Data Set 30 November 2009
Attachment 4: Demographics of the rural medical workforce, Continued

The table below shows the number of practitioners by State and Territory and RA location. NSW has the largest number of practitioners overall and RA 2 is the location with the largest number of practitioners.

<table>
<thead>
<tr>
<th>State</th>
<th>RA 1</th>
<th>RA 2</th>
<th>RA 3</th>
<th>RA 4</th>
<th>RA 5</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>0</td>
<td>949</td>
<td>324</td>
<td>28</td>
<td>2</td>
<td>1303</td>
</tr>
<tr>
<td>NT</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>59</td>
<td>29</td>
<td>93</td>
</tr>
<tr>
<td>Qld</td>
<td>173</td>
<td>532</td>
<td>337</td>
<td>89</td>
<td>38</td>
<td>1169</td>
</tr>
<tr>
<td>SA</td>
<td>0</td>
<td>192</td>
<td>168</td>
<td>49</td>
<td>8</td>
<td>417</td>
</tr>
<tr>
<td>Tas</td>
<td>0</td>
<td>64</td>
<td>114</td>
<td>6</td>
<td>3</td>
<td>187</td>
</tr>
<tr>
<td>Vic</td>
<td>2</td>
<td>708</td>
<td>229</td>
<td>6</td>
<td>0</td>
<td>945</td>
</tr>
<tr>
<td>WA</td>
<td>19</td>
<td>217</td>
<td>220</td>
<td>126</td>
<td>57</td>
<td>639</td>
</tr>
<tr>
<td>Total</td>
<td>194</td>
<td>2662</td>
<td>1397</td>
<td>363</td>
<td>137</td>
<td>4753</td>
</tr>
</tbody>
</table>

Figure 21: Practitioner numbers by State and Territory and ASGC-RA

Specialist shortages

Rural and remote communities generally have a relatively low ratio of specialist medical practitioners proportional to their population.

<table>
<thead>
<tr>
<th>ASGC-RA Classification</th>
<th>FTE specialists per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major cities</td>
<td>122.0</td>
</tr>
<tr>
<td>Inner regional</td>
<td>56</td>
</tr>
<tr>
<td>Outer regional</td>
<td>38</td>
</tr>
<tr>
<td>Remote/very remote</td>
<td>16</td>
</tr>
</tbody>
</table>

Figure 22: FTE specialists per 100,000 population by ASGC-RA

Continued on next page
The GP proceduralist is important in rural and remote medicine because of the lack of population to support sub-specialties; however the latest data demonstrates the proportion of rural practitioners providing procedural services has been decreasing since 2002.

It is difficult to enumerate the number of rural and remote GP proceduralists providing procedural services in RRMA 4 to 7 locations due to non-respondents to the workforce survey used to gather elements of the MDS report. However the known number of practitioners providing specified procedural services as at 30 November 2009 is detailed in the tables below.

<table>
<thead>
<tr>
<th>Procedures</th>
<th>NSW</th>
<th>NT</th>
<th>QLD</th>
<th>SA</th>
<th>Tas</th>
<th>VIC</th>
<th>WA</th>
<th>National*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetics general</td>
<td>98</td>
<td>2</td>
<td>84</td>
<td>61</td>
<td>0</td>
<td>92</td>
<td>101</td>
<td>438</td>
</tr>
<tr>
<td>Obstetrics Normal delivery</td>
<td>109</td>
<td>3</td>
<td>127</td>
<td>78</td>
<td>5</td>
<td>123</td>
<td>138</td>
<td>583</td>
</tr>
<tr>
<td>Surgery Operative</td>
<td>77</td>
<td>2</td>
<td>61</td>
<td>26</td>
<td>3</td>
<td>52</td>
<td>37</td>
<td>258</td>
</tr>
<tr>
<td>Known Proceduralists**</td>
<td>190</td>
<td>5</td>
<td>173</td>
<td>115</td>
<td>6</td>
<td>176</td>
<td>197</td>
<td>862</td>
</tr>
<tr>
<td>Total Practitioners</td>
<td>1303</td>
<td>93</td>
<td>1196</td>
<td>417</td>
<td>187</td>
<td>945</td>
<td>639</td>
<td>4753</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedures</th>
<th>RRMA4</th>
<th>RRMA5</th>
<th>RRMA6</th>
<th>RRMA7</th>
<th>National*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetics general</td>
<td>106</td>
<td>264</td>
<td>28</td>
<td>40</td>
<td>438</td>
</tr>
<tr>
<td>Obstetrics Normal delivery</td>
<td>151</td>
<td>318</td>
<td>64</td>
<td>50</td>
<td>583</td>
</tr>
<tr>
<td>Surgery Operative</td>
<td>70</td>
<td>154</td>
<td>14</td>
<td>20</td>
<td>258</td>
</tr>
<tr>
<td>Known Proceduralists**</td>
<td>218</td>
<td>490</td>
<td>76</td>
<td>78</td>
<td>862</td>
</tr>
<tr>
<td>Total Practitioners</td>
<td>1670</td>
<td>2463</td>
<td>295</td>
<td>325</td>
<td>4753</td>
</tr>
</tbody>
</table>

* GPs practising in RRMA 4-7
** GPs practising in at least one procedural field

Figure 23: Number of practitioners providing procedural services by type, state or territory and RRMA

Continued on next page
Of the 862 procedural practitioners, 323 (37.5%) perform multiple procedures. A Venn diagram illustrating practitioners undertaking single or multiple procedures is displayed at Figure 41 below.

![Venn diagram illustrating numbers undertaking single or multiple procedures](image)

**Figure 24: Venn diagram illustrating numbers undertaking single or multiple procedures**

### Types of Practices

The number of GPs working in each practice type by RRMA is also important data in trying to quantify the potential number of locums which may be required.

<table>
<thead>
<tr>
<th>RRMA</th>
<th>Solo</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>RRMA 4</td>
<td>122</td>
<td>7.5</td>
</tr>
<tr>
<td>RRMA 5</td>
<td>340</td>
<td>14.2</td>
</tr>
<tr>
<td>RRMA 6</td>
<td>18</td>
<td>6.6</td>
</tr>
<tr>
<td>RRMA 7</td>
<td>76</td>
<td>25.3</td>
</tr>
<tr>
<td>Total</td>
<td>556</td>
<td>12.1</td>
</tr>
</tbody>
</table>

**Figure 25: Practice type by RRMA**

### Leave wanted versus leave taken

Respondents to the survey for the Minimum Data Set were asked to indicate the number of weeks leave desired each year and the number of weeks actually taken. Data for valid responses indicate that there is an average of 1.5 week deficit between annual leave wanted and annual leave taken.

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual leave taken</td>
<td>2400</td>
<td>0.50</td>
<td>10</td>
<td>4.56</td>
<td>2.05</td>
</tr>
<tr>
<td>Annual leave wanted</td>
<td>1640</td>
<td>1.00</td>
<td>10</td>
<td>6.10</td>
<td>1.86</td>
</tr>
</tbody>
</table>

**Figure 26: Average leave wanted and average leave taken in weeks**
Attachment 5: NRLP Survey Analysis

Introduction

An online survey addressed respondents’ awareness of and views about the National Rural Locum Program (NRLP), comprising:
• SOLS — Specialist Obstetrician Locum Scheme
• GPALS — General Practitioner Anaesthetist Locum Scheme
• RGPLP — Rural General Practice Locum Program.

The survey consisted of a total of 25 questions, and was designed to gather information from both those who had participated in locum schemes (as locum or host), and those who had not.

The survey used a ‘skip logic’ function so that each respondent answered approximately 5 questions that specifically related to their situation.

It is important to note that the figures provided below in data breakdowns by question or demographic characteristics often do not tally with total number of responses. This can be because:
• it was not compulsory for respondents to answer all questions
• it was not compulsory for respondents to provide specific demographic information about themselves
• multiple responses could be provided for a number of questions
• not all respondents completed the survey.

Whilst the limited number of respondents in any one particular group means that statistically significant quantitative results cannot be drawn, the individual responses do provide a wealth of qualitative data.

A copy of the survey tool is at Attachment 9.

Summary

A total of 244 respondents started the NRLP survey. Of these, 230 specified their state of residence and role/specialty. Nearly 90% (219) completed the survey.

There were responses from both locums and hosts. Forty-four percent of respondents had either been a locum or enquired about becoming a locum. Twenty eight percent of respondents had either had a locum replace them or their staff, or had enquired about having a locum.

Analysis of the demographic characteristics of respondents by role/specialty, state and remoteness classification follows.

It should be noted that the low number of responses to many of the survey questions prevents reliable conclusions to be drawn in relation to the issue raised in those questions. In many cases, the results are no more than indicative for those questions.
Demographic characteristics

Role/specialty

Thirty-five respondents nominated some kind of anaesthetic specialty in their role description, either:
- GP/Obstetrician and GP/Apaeasthetist (11.4% or 4 respondents);
- GP/Apaeasthetist (74.3% or 26); or
- Specialist Apaeasthetist (14.3% or 5).
(No respondents described themselves as GP/Apaeasthetists with another specialty.)

Ninety-one respondents nominated some kind of obstetric specialty in their role description, either:
- GP/Obstetrician and GP/Apaeasthetist (4.4% or 4 respondents);
- GP/Obstetrician with other specialty (1.1% or 1 respondent);
- GP/Obstetrician (53.8% or 49 respondents); or
- Specialist Obstetrician (40.7% or 37 respondents).
Seventy-three respondents identified themselves as General Practitioners, with no specialty.

Forty respondents identified as ‘other’, including 11 practice managers and 3 health service managers.

State

Respondents from every state and territory participated in the survey, although numbers were low from the Northern Territory (1.3%), Australian Capital Territory (1.3%) and Tasmania (3.9%).

The majority of responses (67%) came from NSW, Victoria and Queensland.

<table>
<thead>
<tr>
<th>State</th>
<th>Response count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qld</td>
<td>18.3% (42)</td>
</tr>
<tr>
<td>NSW</td>
<td>26.5% (61)</td>
</tr>
<tr>
<td>ACT</td>
<td>1.3% (3)</td>
</tr>
<tr>
<td>Vic</td>
<td>22.2% (51)</td>
</tr>
<tr>
<td>Tas</td>
<td>3.9% (9)</td>
</tr>
<tr>
<td>SA</td>
<td>10.4% (24)</td>
</tr>
<tr>
<td>WA</td>
<td>16.1% (37)</td>
</tr>
<tr>
<td>NT</td>
<td>1.3% (3)</td>
</tr>
</tbody>
</table>

Table 1: Breakdown of survey respondents by state/territory

Remoteness classification

The Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) system defines Remoteness Area (RA) categories in terms of ‘remoteness’ — the physical distance of a location from the nearest Urban Centre (access to goods and services) based on population size.20 The categories are as follows:

RA1 - Major Cities of Australia
RA2 - Inner Regional Australia
RA3 - Outer Regional Australia
RA4 - Remote Australia
RA5 - Very Remote Australia

Continued on next page

---

Demographic characteristics, Continued

A breakdown of respondents by remoteness classification reveals nearly one third (31.8%) of survey participants were from remote and very remote RA classifications; with just over 4/10 (42.5%) from regional areas.

<table>
<thead>
<tr>
<th>Remoteness classification, continued</th>
<th>RA1</th>
<th>RA2</th>
<th>RA3</th>
<th>RA4</th>
<th>RA5</th>
<th>Don’t know/ not provided</th>
<th>Response count</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.8% (20)</td>
<td>18.6% (42)</td>
<td>23.9% (54)</td>
<td>12.8% (29)</td>
<td>19% (43)</td>
<td>16.8% (38)</td>
<td>226</td>
<td></td>
</tr>
</tbody>
</table>

Table 2: Breakdown of survey respondents by RA classification
Awareness of locum programs and funding

General summary

Overall, a majority of respondents were aware of the existence of the three locum programs:

- SOLS (75.0% or 165/220 respondents)
- the RGPLP (72.2% or 161/223 respondents)
- GPALS (62.0% or 132/213 respondents)

Similar proportions understood that the Australian Government funds SOLS, GPALS and the RGPLP (76.5%) and that financial subsidies are available to offset the cost of locums through these programs (73.5%). (Note that it is not clear from the data whether there were differences in awareness of funding source in relation to each of the three programs individually).

Approximately 13% of respondents took the opportunity to comment on a range of issues related to this question or the programs more generally. These included comments in relation to:

- general quality/efficiency of the programs
  - ‘Great service.’
  - ‘Good schemes but coming off a small base, and not using visiting specialists to provide ongoing procedural education to rural GPs which limits it bang for bucks spent.’
- adequacy of funding level
  - ‘The subsidies do NOT even come close to the prohibitive cost of employing locums.’
  - ‘The subsidies have proven not to be enough to offset locum costs, but they certainly help to ease the financial burden.’
Awareness of locum programs and funding, Continued

The degree of awareness of the three locum programs varied depending on the role/specialty of the respondent.

Anaesthetic specialties
More than 9 out of 10 (91.4%) of the 35 respondents in this group were aware of the existence of the General Practice Anaesthetists Locum Scheme (GPALS) and nearly as many knew of the RGPLP (80% or 28 respondents) and the Specialist Obstetrician Locum Scheme (SOLS) (75.8% or 25 respondents).

Most respondents with an anaesthetic specialty in their role description knew that the programs were funded by the Australian Government (77.1%) and that financial subsidies are available to offset the cost of locums through these programs (80%).

Obstetric specialties
Similarly, there was a very high level of awareness of the various locum programs within this group (91 respondents).

Almost all (95.6%) of this group were aware of the Specialist Obstetrician Locum Scheme (SOLS); and approximately 7 out of 10 knew of GPALS (71.1%) and the RGPLP (74.7%).

Significant numbers of respondents were also aware of the funding source for these programs (91%); and that financial subsidies are available to offset the cost of locums through these programs (85.6%).

General Practitioners
Awareness of the various locum programs appears to be generally lower among GPs who do not have a specialty. While approximately three quarters (74%) are aware of the RGPLP, only about half know of SOLS (55.4%) and GPALS (43.8%).

The percentage of GPs who are aware that the Australian Government funds these programs is also lower (63.4%), as is their knowledge that financial subsidies are available to offset the cost of locums through these programs (58.6%).

Practice managers and health service managers
As noted above, eleven practice managers responded to the survey, and 3 health service managers.

Practice managers were much more aware of the RGPLP (81.8%) than they were of SOLS (36.4%) or GPALS (also 36.4%). Most were aware of the funding source for the programs (72.7%) and the existence of financial subsidies (81.8%).

All three of the health service managers were aware of SOLS. Two knew of GPALS, and only one was aware of the RGPLP. All three were aware of the funding source for the programs and the existence of financial subsidies.

Continued on next page
Analysis by state/territory

Some differences in awareness across states/territories were also evident, although there were relatively few respondents from ACT, Tasmania and the Northern Territory.

Across the remaining states, awareness of SOLS was uniformly high, as can be seen in the table below. Fewer respondents (approximately 6 out of 10) were aware of GPALS, though awareness was slightly higher in South Australia. This was also the case for the RGPLP. Over 70% knew of the funding source for the programs, and there were high levels of awareness in relation to the existence of financial subsidies.

<table>
<thead>
<tr>
<th></th>
<th>Qld</th>
<th>NSW</th>
<th>ACT</th>
<th>Vic</th>
<th>Tas</th>
<th>SA</th>
<th>WA</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOLS</td>
<td>70.7% (29)</td>
<td>71.9% (41)</td>
<td>100.0% (3)</td>
<td>77.6% (38)</td>
<td>75.0% (6)</td>
<td>82.6% (19)</td>
<td>70.6% (24)</td>
<td>100.0% (3)</td>
</tr>
<tr>
<td>GPALS</td>
<td>60.0% (24)</td>
<td>60.7% (34)</td>
<td>100.0% (3)</td>
<td>59.6% (28)</td>
<td>50.0% (4)</td>
<td>77.3% (17)</td>
<td>58.1% (18)</td>
<td>66.7% (2)</td>
</tr>
<tr>
<td>RGPLP</td>
<td>67.5% (27)</td>
<td>64.4% (38)</td>
<td>66.7% (2)</td>
<td>72.9% (35)</td>
<td>88.9% (8)</td>
<td>100.0% (23)</td>
<td>71.4% (25)</td>
<td>66.7% (2)</td>
</tr>
</tbody>
</table>

That the Australian Government funds these programs

<table>
<thead>
<tr>
<th></th>
<th>Qld</th>
<th>NSW</th>
<th>ACT</th>
<th>Vic</th>
<th>Tas</th>
<th>SA</th>
<th>WA</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOLS</td>
<td>75.6% (31)</td>
<td>70.5% (43)</td>
<td>100.0% (3)</td>
<td>84.0% (42)</td>
<td>75.0% (6)</td>
<td>87.5% (21)</td>
<td>71.4% (25)</td>
<td>66.7% (2)</td>
</tr>
<tr>
<td>GPALS</td>
<td>75.6% (31)</td>
<td>66.7% (40)</td>
<td>100.0% (3)</td>
<td>76.0% (38)</td>
<td>75.0% (6)</td>
<td>83.3% (20)</td>
<td>67.6% (23)</td>
<td>100.0% (3)</td>
</tr>
</tbody>
</table>

That financial subsidies are available to offset the cost of locums through these programs

<table>
<thead>
<tr>
<th></th>
<th>Qld</th>
<th>NSW</th>
<th>ACT</th>
<th>Vic</th>
<th>Tas</th>
<th>SA</th>
<th>WA</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOLS</td>
<td>75.6% (31)</td>
<td>66.7% (40)</td>
<td>100.0% (3)</td>
<td>76.0% (38)</td>
<td>75.0% (6)</td>
<td>83.3% (20)</td>
<td>67.6% (23)</td>
<td>100.0% (3)</td>
</tr>
<tr>
<td>GPALS</td>
<td>75.6% (31)</td>
<td>66.7% (40)</td>
<td>100.0% (3)</td>
<td>76.0% (38)</td>
<td>75.0% (6)</td>
<td>83.3% (20)</td>
<td>67.6% (23)</td>
<td>100.0% (3)</td>
</tr>
</tbody>
</table>

Table 3: Awareness of locum program and funding by state

Continued on next page
More than 6 out of 10 respondents across all RA classifications except major cities were aware of the three locum programs, the funding source for the programs, and the availability of subsidies. Knowledge of SOLS and the RGPLP was particularly high in RA 2–5 areas.

<table>
<thead>
<tr>
<th></th>
<th>RA1</th>
<th>RA2</th>
<th>RA3</th>
<th>RA4</th>
<th>RA5</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOLS</td>
<td>40.0%</td>
<td>75.0%</td>
<td>76.0%</td>
<td>77.8%</td>
<td>79.5%</td>
</tr>
<tr>
<td>GPALS</td>
<td>31.6%</td>
<td>63.4%</td>
<td>62.5%</td>
<td>73.1%</td>
<td>67.6%</td>
</tr>
<tr>
<td>RGPLP</td>
<td>65.0%</td>
<td>73.2%</td>
<td>81.1%</td>
<td>74.1%</td>
<td>78.0%</td>
</tr>
<tr>
<td>That the Australian Government funds these programs</td>
<td>70.0%</td>
<td>66.7%</td>
<td>83.0%</td>
<td>79.3%</td>
<td>80.0%</td>
</tr>
<tr>
<td>That financial subsidies are available to offset the cost of locums through these programs</td>
<td>55.0%</td>
<td>66.7%</td>
<td>83.0%</td>
<td>65.5%</td>
<td>77.5%</td>
</tr>
</tbody>
</table>

Table 4: Awareness of locum programs and funding by RA classification
‘I have not had any dealings with a locum service’

General summary

Thirteen percent (33/244 respondents) have had no dealings with a locum service. Just over half of these (17) used internal staff to cover personnel on leave; while one third (11) cover leave periods by using their own personal contacts. Another 15% were not aware of any locum services that they could access. (Note: it is often not possible from the data for this question to determine which of the three programs participants are referring to.)

Other reasons provided for why respondents had had no dealings with locum services included:

- ‘Work through RDWA and they haven't had locums to provide.’
- ‘They are too expensive and paperwork burden is immense.’
- ‘I use locum agencies not services such as SOLS.’

Respondents noted a number of difficulties with using internal staff or personal contacts to cover leave periods. These included:

- cost of travel
  - ‘The problem is that the staff are located nearly 1800km away at a coastal based branch of our practice. We have been told we are ineligible to claim any subsidy to cover air fares!’
- the challenges associated with covering long periods of time for training/professional development purposes:
  - ‘With reducing numbers of some proceduralists, we will need to look at locum cover, but we consider this to be very expensive and to be the hospital’s role, not ours’
  - ‘I need to be covered for 6 months next year so I can learn obstetrics. Any chance of someone covering that?’

Others had been able to tap into local or internal availability:

- ‘We have enough workforce to cover holiday leave.’
- ‘Was able to organise locum using previous employed doctor.’
- ‘Currently excellent local locum availability.’

Continued on next page
‘I have not had any dealings with a locum service’, Continued

Analysis by role/specialty

The data suggests that clinicians with an anaesthetic or obstetric specialty rely more heavily on their own networks to find locum cover than generalist GPs. Internal staff cover is the most common strategy across all role/specialty groups.

<table>
<thead>
<tr>
<th>Analysis by role/specialty</th>
<th>General practitioners</th>
<th>Anaesthetic specialties</th>
<th>Obstetric specialties</th>
<th>Health service manager</th>
<th>Practice manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>I manage leave myself, using my own contacts</td>
<td></td>
<td>62.5% (5)</td>
<td>50.0% (4)</td>
<td>100.0% (2)</td>
<td></td>
</tr>
<tr>
<td>I don't use a replacement</td>
<td>10% (1)</td>
<td>12.5% (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am / we are not aware of any locum services</td>
<td></td>
<td></td>
<td>30% (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I / we can't afford a locum service</td>
<td></td>
<td></td>
<td></td>
<td>10% (1)</td>
<td></td>
</tr>
<tr>
<td>We use internal staff to cover staff on leave</td>
<td>50% (5)</td>
<td>50.0% (4)</td>
<td>50.0% (4)</td>
<td>50.0% (1)</td>
<td></td>
</tr>
</tbody>
</table>

No. of respondents (Multiple responses could be provided.)

| | General practitioners | Anaesthetic specialties | Obstetric specialties | Health service manager | Practice manager |
|----------------------------|-----------------------|-------------------------|-----------------------|-----------------|
| | 10 | 10 | 10 | 0 | 2 |

Table 5: Lack of dealings with a locum service by role/specialty

Analysis by state

The data implies that the two main reasons for not having had dealings with a locum service - ‘I manage leave myself, using my own contacts’ and ‘We use internal staff to cover staff on leave’ - are common across states/territories.

<table>
<thead>
<tr>
<th>Analysis by state</th>
<th>Qld</th>
<th>NSW</th>
<th>ACT</th>
<th>Vic</th>
<th>Tas</th>
<th>SA</th>
<th>WA</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>I manage leave myself, using my own contacts</td>
<td>60% (3)</td>
<td>33.3% (4)</td>
<td></td>
<td>12.5% (1)</td>
<td></td>
<td>40% (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don't use a replacement</td>
<td></td>
<td></td>
<td></td>
<td>12.5% (1)</td>
<td></td>
<td>20% (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don't take leave</td>
<td></td>
<td></td>
<td></td>
<td>100% (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am / we are not aware of any locum services</td>
<td></td>
<td></td>
<td></td>
<td>41.7% (5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I / we can't afford a locum service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12.5% (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>We use internal staff to cover staff on leave</td>
<td>20% (2)</td>
<td>41.7% (5)</td>
<td></td>
<td>87.5% (7)</td>
<td></td>
<td>100% (1)</td>
<td>40% (2)</td>
<td></td>
</tr>
</tbody>
</table>

No. of respondents (Multiple responses could be provided.)

<table>
<thead>
<tr>
<th></th>
<th>Qld</th>
<th>NSW</th>
<th>ACT</th>
<th>Vic</th>
<th>Tas</th>
<th>SA</th>
<th>WA</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>12</td>
<td>0</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 6: Lack of dealings with a locum service by state

Continued on next page
The two main reasons for not having had dealings with a locum service - 'I manage leave myself, using my own contacts' and 'We use internal staff to cover staff on leave' - also appear to hold true across remoteness area classification.

<table>
<thead>
<tr>
<th>Reason</th>
<th>RA1</th>
<th>RA2</th>
<th>RA3</th>
<th>RA4</th>
<th>RA5</th>
</tr>
</thead>
<tbody>
<tr>
<td>I manage leave myself, using my own contacts</td>
<td>18.2% (2)</td>
<td>25% (2)</td>
<td>40% (2)</td>
<td>60% (3)</td>
<td></td>
</tr>
<tr>
<td>I don't use a replacement</td>
<td>18.2% (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don't take leave</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>20% (1)</td>
</tr>
<tr>
<td>I am / we are not aware of any locum services</td>
<td>18.2% (2)</td>
<td>12.5% (1)</td>
<td>20% (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I / we can't afford a locum service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12.5% (1)</td>
</tr>
<tr>
<td>We use internal staff to cover staff on leave</td>
<td>100% (2)</td>
<td>63.6% (7)</td>
<td>50% (4)</td>
<td>40% (2)</td>
<td>20% (1)</td>
</tr>
<tr>
<td><strong>No. of respondents</strong> <em>(Multiple responses could be provided.)</em></td>
<td>2</td>
<td>11</td>
<td>8</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 7: Lack of dealings with a locum service by RA classification
‘I enquired requesting a locum to replace me / my staff but did not proceed’

Locum services approached

Three respondents responded to this statement. The locum services approached were:

1. SOLS
2. Both RGPLP and Queensland Health
3. Both RGPLP and Rural Workforce Agency

The respondents were:

• a very remote Queensland practice manager (RA5)
• a General Practitioner from an outer regional area of South Australia (RA3)
• a Specialist Obstetrician from an inner regional area in Victoria (RA2).

Factors influencing decision not to proceed

The factors that most strongly influenced respondents in choosing not to proceed with a locum were as follows, in this order (multiple selections could be made):

• the availability of a locum for the required dates
• the availability of a locum with the right clinical skills
• insufficient subsidy
• too much paperwork.
‘I have used a locum service’

Locum services used by respondents

Forty four responses were received in relation to this statement. Respondents could make multiple selections in their answers.

Many respondents had used more than one locum service. Over half (54.5%) had used SOLS, and 41% had used the RGPLP. Only 9.1% (4 respondents) had used GPALS.

Nine respondents had also used private locums, identified through local contacts, a ‘freelance’ locum and private agencies. Other sources included Health Workforce Queensland, Rural Health West, North East Victorian Division of General Practice, Rural Doctors Workforce Agency, Rural Doctors’ Association and New South Wales Rural Doctors Network.

Analysis of locum program use by state/territory

A state-by-state breakdown is provided below. Numbers are too low to draw any rigorous conclusions about the difference in usage between the various states and territories.

<table>
<thead>
<tr>
<th></th>
<th>Qld</th>
<th>NSW</th>
<th>ACT</th>
<th>Vic</th>
<th>Tas</th>
<th>SA</th>
<th>WA</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOLS</td>
<td>57.1% (4)</td>
<td>30% (3)</td>
<td>72.7% (8)</td>
<td>33% (2)</td>
<td>62.5% (5)</td>
<td>100% (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GPALS</td>
<td>14.3% (1)</td>
<td>10% (1)</td>
<td>10% (1)</td>
<td>25% (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RGPLP</td>
<td>14.3% (1)</td>
<td>70% (7)</td>
<td>18.2% (2)</td>
<td>67% (4)</td>
<td>50% (4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not sure/don’t remember</td>
<td>14.3% (1)</td>
<td>9.1% (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Others include: Health Workforce Qld, private agencies, skilled medical, AMP, RDN NSW, RDA, private agencies, Rural Doctors Workforce Agency, RHW, Rural Health West, private agencies, global medical, AMA

| No. of respondents (Multiple responses could be provided.) | 7 | 10 | 0 | 11 | 0 | 6 | 8 | 2 |

Table 8: Locum program use by state/territory

Continued on next page
A further breakdown of the data by role/specialty is provided below. The data implies that those respondents with obstetric specialties are more likely to use locum services in general. Some respondents also appear to use/have used multiple locum programs.

<table>
<thead>
<tr>
<th></th>
<th>General practitioners</th>
<th>Anaesthetic specialties</th>
<th>Obstetric specialties</th>
<th>Health service manager</th>
<th>Practice manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOLS</td>
<td>64% (16)</td>
<td></td>
<td>100% (3)</td>
<td>50% (3)</td>
<td></td>
</tr>
<tr>
<td>GPALS</td>
<td>8% (2)</td>
<td></td>
<td>33.3% (1)</td>
<td>16.7% (1)</td>
<td></td>
</tr>
<tr>
<td>RGPLP</td>
<td>100% (6)</td>
<td>100% (3)</td>
<td>24% (6)</td>
<td>66.7% (4)</td>
<td></td>
</tr>
<tr>
<td>Not sure/don’t remember</td>
<td>8% (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| No. of respondents (Multiple responses could be provided.) | 6 | 3 | 25 | 3 | 6 |

Table 9: Locum program use by role/specialty

The data could suggest most active use of locum programs in outer regional areas, with some respondents also appearing to use/have used multiple locum programs.

<table>
<thead>
<tr>
<th></th>
<th>RA1</th>
<th>RA2</th>
<th>RA3</th>
<th>RA4</th>
<th>RA5</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOLS</td>
<td>1</td>
<td>1</td>
<td>8</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>GPALS</td>
<td>2</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>RGPLP</td>
<td>2</td>
<td>9</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Not sure/don’t remember</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| No. of respondents | 1 | 4 | 17 | 6 | 8 |

Table 10: Locum program use by RA classification
Factors considered to be important in choosing a locum service

A broad combination of factors were considered by respondents in choosing a locum service. Over 90% of respondents identified the following factors as ‘important’ or ‘very important’:

- a short time lag between initial enquiry and getting a locum
- the travel allowance
- ease of communication with the locum agency.

The following cluster of factors were also identified as ‘important’ or ‘very important’ by over 75% of respondents:

- the subsidy available through the locum service
- support from the locum agency
- a proven track record in providing locums
- no administrative fee
- minimal amount of paperwork required
- information about, and assistance with, insurance, registration and other professional / credentialing issues
- a previous relationship with the agency
- backing of a professional college / association
- practical assistance with travel and accommodation
- a structured clinical handover

Benefits for the clinician

Respondents identified a range of personal benefits from using a locum service. Of most significance was the opportunity to obtain a break from work — to prevent burnout, spend time with family, and have a holiday:

- ‘Finally able to get a holiday with the family, would not have lasted much longer without.’
- ‘Ability to get away with family and have a break.’
- ‘Provided much needed relief.’

Other benefits identified by respondents included:

- subsidised costs making a break more affordable
  - ‘A break without huge financial cost.’
  - ‘Access to the rebate to assist with expenses.’

- ability to reduce pressures of workload on themselves or colleagues
  - ‘Sharing of workload.’
  - ‘Helps colleagues cope in my absence.’
  - ‘Don’t have a mountain of work on my return.’

- peace of mind while away
  - ‘Ability to be able to leave town and not worry about practice and hospital.’
  - ‘Peace of mind while on maternity leave.’

- the opportunity for education or professional development
  - ‘Chance to get refreshed in education ...’
  - ‘Allowed me to travel to go to an overseas meeting.’

- continuity of service to patients
  - ‘Ability to keep practice running while away.’
  - ‘I didn't have to shut up shop.’

Respondents also noted the advantages of obtaining a good quality locum, and the broader benefits of being ‘able to keep GP numbers up’ in rural areas.
‘I have used a locum service’, Continued

Benefits for patients

Respondents also identified benefits to their patients through their use of a locum service. Overwhelmingly this related to the ability to provide continuity of service in their community:

- ‘Not having to travel to another town to obtain service.’
- ‘To be able to keep providing the same level of service.’
- ‘Can still deliver locally, instead of going 50km to next town.’
- ‘Continuity of medical care in my absence. Due to relative isolation no alternatives for many.’

Other identified benefits for patients included:
- the advantages of seeing ‘fresh’ personnel:
  - ‘Get different opinion and compare with their own doctor.’
- having a ‘rested and relaxed doctor’ to provide service on his/her return
- the contribution made by locum services in ‘ensuring [an] ongoing viable medical workforce in the area.’

Benefits for the community

Similar themes emerged in the benefits for their community identified by respondents. Continuity of service was again a major factor:

- ‘Provision of ongoing care and no delays in obtaining consultations, also new techniques shown.’
- ‘Service provided locally, no need to transfer patients.’
- ‘Ability to continue providing a service while current staff are on leave.’

Other factors identified included:

- ability to reduce pressures of workload on colleagues
  - ‘My colleagues don’t have to take up the slack.’
  - ‘Less impact on my obstetric colleagues.’
- contribution to attraction and retention of medical personnel:
  - ‘Chance [that] locum doctor [might] relocate to country area.’
  - ‘Avoiding GP burnout and doctors leaving because of overwork.’
  - ‘Helps in ensuring ongoing viable medical workforce in the area.’

Benefits for the locums

Respondents also saw significant benefits for the locums themselves. These almost without exception related to the opportunity for new and diverse experiences, well paid, in a supportive environment:

- ‘An interesting and varied workplace and community.’
- ‘Enjoyable experience with good appreciation and remuneration.’
- Opportunity to work in a supportive practice/community, travel.’
- ‘Working in a pleasant community for grateful patients with a varied interesting workload.’
- ‘Hopefully enjoys the experience of county remote experience seeing other services, how things can be done differently.’
- ‘See a different community with more challenging medicine.’

Continued on next page
Approximately one third of respondents (11/34) had had no negative experiences with locums.

Approximately another third (12/34), however, noted issues with the quality of locums they had used in relation to their interest in the work, currency of practice and knowledge of current Medicare item numbers.

In some cases, difficulties were related to the expectations of the locums or willingness to work under the same conditions as the permanent clinician, such as after hours work, ‘on call’ requirements and VMO responsibilities.

Respondents also noted that some patients had difficulty accepting locums:

- ‘Patients still wait to see me rather than see locum.’
- ‘Some patients find it difficult to relate to the locum, particularly the elderly and children.’

‘Red tape’ and financial considerations were also highlighted by a small number of respondents.

---

*Continued on next page*
Fifty respondents identified their plans for using particular locum services in the next 12 months. Multiple responses were possible.

Of the fifty respondents, 44% (22) planned to use SOLS, with nearly as many (38% or 19 respondents) planning to use RGPLP or other locum services (36.0% or 18). As can be seen in Figure 1 below, fewer respondents aimed to use GPALS, or were not planning to use a locum.

![Figure 1: Plans to use locum services in next 12 months](chart)

Many respondents provided brief comment in relation to why they would be seeking the services of a locum in the next twelve months. Many of the reasons have been highlighted above, including the need for a break from the pressures of work; for continuing education and attendance at conferences; and confidence in the provision of a good quality service.

A number of respondents also identified the need to rely on locums while recruiting for new colleagues:

- ‘Excellent service and the need remains at the present time due to a recruiting period for full time staff member.’
- ‘My group of doctors are leaving and I need locums until I get permanents.’

Continued on next page
‘I have not offered my services as a locum’

Factors influencing decision not to offer services

Twenty-eight responses were received to this question.

The factors that most strongly influenced respondents in choosing not to offer their services as a locum were as follows, in this order (multiple selections could be made):

- I work fulltime (78.6%)
- I have family commitments that prevent me being away (17.9%)
- I am not interested (14.3%)
- I don’t feel comfortable working in someone else’s practice (3.6%)
- I don’t feel I have the skills to take on a rural case load (3.6%)
- I have not really thought about it (3.6%).

Factors that would influence respondents to consider offering their services as a locum

Almost all respondents identified a change of work circumstances as the factor most likely to influence them to offer their services as a locum. This included retirement, part time work rather than full time, or a change of employer:

- ‘Be working part time.’
- ‘I will consider this in a couple of years when I am semi retired.’
- ‘I would need a locum myself!’
- ‘I would need to leave my current employment.’

Several noted factors related to lifestyle and personal commitments, including work for their partners:

- ‘Unlikely to happen at the moment, maybe when the children have left home.’
- ‘GP obs husband would also need to find work at the same time & place.’
- ‘I would need a suitable practitioner to replace me for the designated period and my practice manager/RN/spouse would also need replacing.’
- ‘Interesting location my husband felt he could visit.’

A number of respondents also identified remuneration as a factor:

- ‘The incentive will have to be better than the highest earning in my practice.’
- ‘The employer of the locum had to provide indemnity cover.’
- ‘… probably some financial incentive.’

Continued on next page
‘I have not offered my services as a locum’, Continued

**Analysis by state**

Respondent numbers to this question are too low to draw reliable conclusions about differences across states, although the data could suggest that working full time is a key factor in why respondents have not offered their services as a locum regardless of the state or territory in which they live.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Qld</th>
<th>NSW</th>
<th>ACT</th>
<th>Vic</th>
<th>Tas</th>
<th>SA</th>
<th>WA</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am not interested</td>
<td>20% (1)</td>
<td>25% (2)</td>
<td>100% (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I work full time</td>
<td>60% (3)</td>
<td>75% (6)</td>
<td>83.3% (5)</td>
<td>100% (1)</td>
<td>100% (6)</td>
<td>100% (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don’t feel comfortable working in someone else’s practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16.7% (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don’t feel I have the skills to take on a rural case load</td>
<td>12.5% (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have not really thought about it</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16.7% (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have family commitments that prevent me being away</td>
<td>40% (2)</td>
<td>25% (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16.7% (1)</td>
<td></td>
</tr>
<tr>
<td>No. of responses (Multiple responses could be provided.)</td>
<td>5</td>
<td>8</td>
<td>1</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 11: Reasons for not having offered services as a locum by state

Continued on next page
The data suggests that the two main reasons for not having offered their services as a locum (‘I work fulltime’ and ‘I have family commitments that prevent me being away’) are consistent across all roles/specialties.

### General practitioners

<table>
<thead>
<tr>
<th>Reason</th>
<th>Analysis by role/specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am not interested</td>
<td>42.9% (3)</td>
</tr>
<tr>
<td>I work full time</td>
<td>57.1% (4)</td>
</tr>
<tr>
<td>I don’t feel comfortable working in someone else’s practice</td>
<td>14.3% (1)</td>
</tr>
<tr>
<td>I don’t feel I have the skills to take on a rural case load</td>
<td>14.3% (1)</td>
</tr>
<tr>
<td>I have not really thought about it</td>
<td>14.3% (1)</td>
</tr>
<tr>
<td>I have family commitments that prevent me being away</td>
<td>28.6% (2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of responses (Multiple responses could be provided.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>11</td>
</tr>
</tbody>
</table>

### Anaesthetic specialties

<table>
<thead>
<tr>
<th>Reason</th>
<th>Analysis by role/specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am not interested</td>
<td>9.1% (1)</td>
</tr>
<tr>
<td>I work full time</td>
<td>85.7% (6)</td>
</tr>
<tr>
<td>I don’t feel comfortable working in someone else’s practice</td>
<td>14.3% (1)</td>
</tr>
<tr>
<td>I don’t feel I have the skills to take on a rural case load</td>
<td>14.3% (1)</td>
</tr>
<tr>
<td>I have not really thought about it</td>
<td>14.3% (1)</td>
</tr>
<tr>
<td>I have family commitments that prevent me being away</td>
<td>9.1% (1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of responses (Multiple responses could be provided.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>11</td>
</tr>
</tbody>
</table>

### Obstetric specialties

<table>
<thead>
<tr>
<th>Reason</th>
<th>Analysis by role/specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am not interested</td>
<td>9.1% (1)</td>
</tr>
<tr>
<td>I work full time</td>
<td>90.9% (10)</td>
</tr>
<tr>
<td>I don’t feel comfortable working in someone else’s practice</td>
<td>14.3% (1)</td>
</tr>
<tr>
<td>I don’t feel I have the skills to take on a rural case load</td>
<td>14.3% (1)</td>
</tr>
<tr>
<td>I have not really thought about it</td>
<td>14.3% (1)</td>
</tr>
<tr>
<td>I have family commitments that prevent me being away</td>
<td>9.1% (1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of responses (Multiple responses could be provided.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>11</td>
</tr>
</tbody>
</table>

**Table 12: Reasons for not having offered services as a locum by specialty**

The data suggests that working full time is a key factor in why respondents have not offered their services as a locum across all regions, from metropolitan through to very remote regions.

### RA classification

<table>
<thead>
<tr>
<th>Reason</th>
<th>Analysis by RA classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am not interested</td>
<td>RA1 33.3% (1)</td>
</tr>
<tr>
<td>I work full time</td>
<td>RA2 40% (2)</td>
</tr>
<tr>
<td></td>
<td>RA3 25% (1)</td>
</tr>
<tr>
<td></td>
<td>RA4 66.7% (2)</td>
</tr>
<tr>
<td></td>
<td>RA5 85.7% (6)</td>
</tr>
<tr>
<td></td>
<td>60% (3)</td>
</tr>
<tr>
<td></td>
<td>75% (3)</td>
</tr>
<tr>
<td></td>
<td>83.3% (5)</td>
</tr>
<tr>
<td>I don’t feel I have the skills to take on a rural case load</td>
<td>14.3% (1)</td>
</tr>
<tr>
<td>I haven’t really thought about it</td>
<td>25% (1)</td>
</tr>
<tr>
<td>I have family commitments that prevent me being away</td>
<td>100% (3)</td>
</tr>
<tr>
<td></td>
<td>20% (1)</td>
</tr>
<tr>
<td></td>
<td>16.7% (1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of responses (Multiple responses could be provided.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>6</td>
</tr>
</tbody>
</table>

**Table 13: Reasons for not having offered services as a locum by RA classification**
‘I enquired about being a locum but did not proceed’

Factors influencing decision to proceed with a placement as a locum

Twenty-two people responded to this question.

The factors that most strongly influenced respondents in choosing not to proceed with a placement as a locum were as follows (multiple selections could be made):

- Unable to fit into work schedule (50% or 11 respondents)
- It was too difficult to arrange registration, credentialing (45.5% or 10 respondents)
- There is not sufficient financial incentive (27.3% or 6 respondents)
- The amount of paperwork I had to do to be a locum was too much (27.3% or 6 respondents).

Several respondents particularly mentioned their discomfort at having to negotiate remuneration themselves, rather than knowing rates in advance to inform their decision:

- ‘Was looking at SOLS locum — told ‘contact practice direct to organise remuneration’ — not something I’m comfortable with — better to know rates in advance and let that decide availability.’
- ‘Too short a lead time, unclear remuneration.’
- ‘Credentialling needs to be undertaken individually at each individual hospital. Rather than central references held by third party my referees would have been approached by EVERY HOSPITAL for each locum date. This is unacceptable intrusion on my referees. I use a private locum agency for my usual locums and they hold a single copy of my references which are forwarded to any new hospital I work and thus my referees are only approached once when I register with the agency. A central reference scheme is necessary for me to be willing to be involved in program. I work frequently as a locum by stay using commercial locum agencies because of this issue. Also advertisements do not usually give a range for remuneration and I do not wish to have to personally negotiate always directly with the practice without knowing what range of payments they are expecting to pay.’

What would it take for you to proceed with a placement as a locum?

Responses to this question had a clear link to the factors identified above.

Approximately half of the 25 respondents addressed time and availability constraints, including:

- ‘Fit into my family schedule.’
- ‘Suitable timing with current work.’
- ‘Less able to fit in locums than I’d originally thought when signed up.’
- ‘More notice about when a locum may be required. I know this is hard.’

Streamlined processes for paperwork and administration were also an incentive for nearly one third of respondents:

- ‘Help to overcome the above! It was all too hard.’
- ‘SOMEONE TO DO THE PAPERWORK.’
- ‘… Flights/accommodation/travel sorted…’
- ‘Greater flexibility in scheduling locus times/placements. One body of people managing this initiative.’
‘I enquired about being a locum but did not proceed’ Continued

Improved remuneration was also identified as an incentive:

- ‘Better remuneration.’
- ‘The few I’ve enquired about would pay only ~ 60% what I get here doing similar job. I’d expect to be paid at least equal and prob > to go away to a remoter location and have to arrange cover here etc.’
- ‘Money $2-2.5K per day.’

Analysis by state, role/specialty and remoteness classification

Within the low number of responses to this question, breakdown of data by state, role/specialty and remoteness classification did not reveal any discernable patterns in the factors influencing respondents’ decisions not to proceed with a placement as a locum.

While the factors identified above - ‘Unable to fit into work schedule’ and ‘too difficult to arrange registration, credentialing’ - were prominent across all groupings, many respondents further identified a scattered range of issues. The following diagrams, for example, depict the diversity of factors identified by New South Wales and Victorian respondents, by those with obstetric specialties, and those in remote regions (RA4). A similarly diverse picture was evident in other states, roles/specialties and remoteness area classifications.

This suggests that most respondents were influenced by multiple factors in making a decision as to whether to proceed with a locum placement.

Continued on next page
‘I enquired about being a locum but did not proceed’ Continued

Figure 2: Factors influencing respondents’ decisions not to proceed with a placement as a locum — NSW respondents

Figure 3: Factors influencing respondents’ decisions not to proceed with a placement as a locum — Victorian respondents

Continued on next page
‘I enquired about being a locum but did not proceed’, Continued

Figure 4: Factors influencing respondents’ decisions not to proceed with a placement as a locum — respondents with an obstetric specialty

Figure 5: Factors influencing respondents’ decisions not to proceed with a placement as a locum — respondents classified RA4
‘I am / have been a locum’

Locum service(s)/program(s) used

Forty five responses were received to this question.

Just over half (53%) of respondents had used or are using SOLS; and approximately one third (37.8%) had used/were using the RGPLP.

Significantly fewer (13.3%) had used/were using GPALS. A small number (4.4%) were unsure of which program they had used, or could not remember the program name.

A breakdown of these figures by state, role/specialty and remoteness classification appears in Table 14.

Benefits from being a locum

Seventy-five respondents identified a range of benefits attributed to being a locum.

The benefits most commonly identified were as follows (multiple responses were possible):

- Assisting my colleagues (80% or 60 respondents)
- Seeing more of Australia (66.7% or 50 respondents)
- Using more of my skill base (65.3% or 49 respondents).
- Provides a lifestyle choice (52% or 39 respondents).

Many respondents identified personal benefits related to personal development and lifestyle choices and/or career satisfaction:

- ‘To work /contribute in Indigenous health.’
- ‘I can make a difference where the cities are restrictive and protected by specialist groups with little or no understanding of the value of doctors such as myself.’
- ‘Experiencing other health services also generates new ideas for my usual workplace. I may seek to re-locate to another rural area to work in the future based on locum experiences.’
- ‘Able to gain a better understanding of the medical politics in the Australian health care problems and issues.’
- ‘I have an affinity for rural people — they do it tough.’

Many respondents also noted that ‘income supplementation’ was an attraction. This included those who used locum placements to contribute to their retirement income or support more flexible career paths:

- ‘I am semi-retired and locum work in rural public hospitals suits my financial needs.’
- ‘I work voluntarily overseas half the year and locums are the best way of gaining employment.’
- ‘Supplement income in retirement.’
- ‘I have recently moved to a new country town and they have regular doctors (so don’t need me), but I try to locum for them so I can work at home and support them.’

Continued on next page
Analysis by state

The data suggests that SOLS and the RGPLP are most commonly used to facilitate locum placements across all states/territories. Respondents had also used multiple agencies, including private agencies such as Wavelength and Ochre.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Qld</th>
<th>NSW</th>
<th>ACT</th>
<th>Vic</th>
<th>Tas</th>
<th>SA</th>
<th>WA</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOLS</td>
<td>20% (2)</td>
<td>66.7% (8)</td>
<td>80% (8)</td>
<td>50% (1)</td>
<td>25% (1)</td>
<td>50% (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GPALS</td>
<td>30% (3)</td>
<td>16.7% (2)</td>
<td>16.7% (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RGPLP</td>
<td>40% (4)</td>
<td>33.3% (4)</td>
<td>20% (2)</td>
<td>50% (1)</td>
<td>75% (3)</td>
<td>50% (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not sure/don't remember</td>
<td>20% (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other:
- Ausstat (2), Ochre, Wavelength (3), Skilled Medical Pty Ltd.
- Last Minute Locums, Ochre, GPNTT (2), Skilled Medical, Wavelength, Ausstat
- Skilled Medical, Ochre, GPNTT, Chandler McLeod
- Ochre, GPNTT, Wavelength (2)
- RDWA, CHSA, Bone, Wavelength, Health 24
- Ochre, WACHS, Rural Health West

| No. of responses (Multiple responses could be provided.) | 10 | 12 | 2 | 10 | 2 | 4 | 6 | 0 |

Table 14: Locum services used by state/territory

Continued on next page
While no definitive conclusions can be drawn from these numbers, the data demonstrates that respondents across all roles/specialties are using multiple agencies to facilitate their locum placements.

### Analysis by role/specialty

<table>
<thead>
<tr>
<th>Role/Specialty</th>
<th>General Practitioners</th>
<th>Anaesthetic Specialties</th>
<th>Obstetric Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOLS</td>
<td>92.3% (24)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GPALS</td>
<td>100% (5)</td>
<td>3.8% (1)</td>
<td></td>
</tr>
<tr>
<td>RGPLP</td>
<td>100% (12)</td>
<td>60% (3)</td>
<td>7.7% (2)</td>
</tr>
</tbody>
</table>

Other: Wavelength (3), Ochre (4), GPNTT (4), Skilled Medical (3), Chandler McLeod, CHSA, WACHS, Rural Health West, Charterhouse

| No. of responses (Multiple responses could be provided.) | 12 | 5 | 26 |

*Table 15: Locum services used by role/specialty*

### Analysis by remoteness classification

Again, low numbers prevent definitive conclusions being drawn, but the data below suggests that each of the programs is being used across all remoteness classifications. The exception is RA4 (remote Australia), where all respondents have used private agencies. Further research would be required to determine whether this is a reflection of actual circumstances in remote regions, or simply coincidental given the particularly low number of respondents.

<table>
<thead>
<tr>
<th>Remoteness Classification</th>
<th>RA1</th>
<th>RA2</th>
<th>RA3</th>
<th>RA4</th>
<th>RA5</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOLS</td>
<td>42.9% (3)</td>
<td>42.9% (3)</td>
<td>60% (3)</td>
<td>12.5% (1)</td>
<td></td>
</tr>
<tr>
<td>GPALS</td>
<td>28.6% (2)</td>
<td>28.6% (2)</td>
<td></td>
<td>12.5% (1)</td>
<td></td>
</tr>
<tr>
<td>RGPLP</td>
<td>28.6% (2)</td>
<td>57.1% (4)</td>
<td>40% (2)</td>
<td>62.5% (5)</td>
<td></td>
</tr>
<tr>
<td>Not sure/don't remember</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25% (2)</td>
</tr>
</tbody>
</table>

Other: Last Minute Locums, GPNTT, Wavelength Ochre, GPNTT, Skilled Medical (2), Wavelength (2), CHSA, Bone

<table>
<thead>
<tr>
<th>Wavelength, Ochre, Medical Agency, CHSA, WACHS, Private agency, Ochre (3), Chandler McLeod, GPNTT, Ausstat</th>
</tr>
</thead>
</table>

| No. of responses (Multiple responses could be provided.) | 7 | 7 | 5 | 4 | 8 |

*Table 16: Locum services used remoteness classification*

*Continued on next page*
‘I am / have been a locum’ Continued

Locations where locum service has been provided:

**Qld**

Mornington Island, Mt Isa x3, Beaudesert, South Brisbane, Atherton, Roma x3, Mossman x2, Weipa, Mackay, Glenden, Proserpine, Sarina, Mirani, Moranbah, Airlie Beach, Cannonvale, Walkerston, Cunnamulla, Emerald x3, Blackwater, Thursday Island x2, Biloela x2, Palm Island, Mareeba, Ingham, magnetic island, Mt Morgan, Barcaldine, Blackall, Yarrabah, Clermont, Normanton, Kingaroy, Clermont, Nambour, Hervey Bay, Bundaberg x2, Nambour x3, Goondiwindi, Cairns, Redland Bay, Atherton, Mosman.

**NSW**

Queanbeyan, Bateman's Bay, Grafton x3, Murwillumbah x3, Cowra x2 (GP Anaes & ED), Collarenebri, Nyngan, Forbes, Tenterfield, Glenden, La Trobe, Mildura, Gin Gin, Childers, Armidale x2, Tamworth, Grafton, South West Rocks, Canowindra, Albury, Casino, Gunnedah, Byron Bay, Moree, Hillston, Warren, Trangie, Narromine, Bingara, Molong, Cobram, Robinvale, Condobolin, lake Cargelligo, Nyngan, Cobar, Bega x3, Hay, Griffith x2, Lismore x2, Orange, Gosford x2, Nowra x3, Goulburn x2, Taree x3, Griffith, Broken Hill, Wagga Wagga x3, Kempsey, Bowral x2, Tweed Heads, Coffs Harbour.

**ACT**

Canberra.

**Vic**

Yarram (GP & ED), Maldon, Inglewood, Cobden, Penshurst, Timboon, Bentleigh, Dandenong, Wantirna, Gippsland, Mildura x3, Wangaratta, Bendigo x3, Shepparton x5, Sale, Wodonga, Warragul x3, Warrnambool x3.

**Tas**

Rural areas (GP), St Marys x2, King Island, Launceston x4, Rosebery, Zeehan, Latrobe x2, Burnie, Hobart.

**SA**

Rural SA (RDWA), Kangaroo Island x3, Coober Pedy x2, Streaky Bay x2, Wudinna x2, Victor Harbour, Jamestown, Tanunda, Ceduna x3, Roxby Downs, Orroroo, Cummins, Pinaroo, Penola, Quorn, Cowell, Burra, Port Pirie x2, Keith, Mt Gambier, Elliston, Cleve, Port Lincoln, Laura, Maitland, Whyalla, Gumeracha, Boolaroo Centre, Peterborough, Wudinna, Meningee, Robe, Port Broughton, Berri x2, Murray Bridge.

**WA**

Fitzroy Crossing, Derby x4, Kalgoorlie x3 (GP), Jigalong, Christmas Island x2, Kimberley x2, Wyndham x2, Halls Creek, Kununurra x3 (GP anaesthetist), Northam, Esperance, Broome x4, Karratha x3, Dalwallnun, Gnowangerup, Bunbury, Port Hedland x3, Pilbara, Fremantle, Ravensthorpe, Margaret River, Albany, Lake Grace, Condining Hill.

**NT**

Central Australia, Oenpelli Gove x2, Alice Springs x6, Miwati, Darwin x2.
What do you believe needs to be done to better support rural medical practitioners take leave?

Summary
This question was answered by 173 respondents, across all state/territories, roles/specialties, and remoteness classifications.

A number of themes could be identified in the range of responses. In order of importance, these related to:
• the importance of continuing to fund and/or provide additional funding for locum services and programs
• the need for an increased number of locums
• additional incentives for locums
• the need for improved planning.

The following issues were also identified by approximately 6-8 respondents each:
• reduced paperwork
• the need to provide improved information for potential locums
• the need for additional awareness raising related to the locum programs
• the value of country service
• the need to ensure an effective match between the GP and locum.

The major themes are discussed in further detail below.

Continuing/additional funding for locum programs
Over one third (36%) of respondents noted the importance of continuing to fund and/or provide additional funding for locum services and programs.

- ‘More vigorous locum services — well funded & professional. Assist some of the better private locum services as well as the government funded eg GPNNT.’
- ‘Continue to subsidise practice overheads as well as locum’s fees.’
- ‘Increasing the availability of these programs would be great eg RGPLP is a tiny number of positions for the need.’

Increased number of locums
Over one fifth (21%) of respondents highlighted the need for increased numbers of locums in general, and particularly those who know rural practice:

- ‘Recruit more locums by making the program more attractive.’
- ‘What about funding permanent locums that go around and provide leave relief where it hasn’t been taken in say 2 years?’
- ‘Improved availability of procedural locums that can work in general practice.’
- ‘More skilled doctors based in areas so you can get a returning locum that knows your area and services available. Having locums from Brisbane who don't know where to refer or what a PTS form is frustrating, costly & time consuming.’
What do you believe needs to be done to better support rural medical practitioners to take leave? Continued

**Additional incentives**

Over one fifth (21%) of respondents also noted the need for additional incentives to encourage clinicians to offer their services as a locum.

The issue of private indemnity cover was raised most consistently:

- ‘Private indemnity is an issue as too expensive for the practice principal to pay in a part or full private practice situation. I as many others will only do public hospital locums [who cover our indemnity] as a consequence.’
- ‘Private indemnity cover provided for locums doing short term cover for private specialist practitioners.’
- ‘Evaluate and address the problem of Medical Indemnity Insurance for part-time practitioners who wish to provide locum services to private practitioners.’
- ‘Semi-retired practitioner will not be able to do locum unless the employer provide full indemnity cover.’

**Improved planning**

Ten percent of respondents identified improved planning processes at a range of levels as a key area of need.

- ‘There should be long term planning rather than last minute urgent locum calls.’
- ‘A bit more notice of placement availability dates.’
- ‘Rural practices/hospitals linked to other urban/regional practices and hospitals to work as one co-ordinated network to share resources and minimise locum use.’
- a. A realistic leave period, eg 3 to 4 weeks, as less than this means that patients will usually defer the consultation until the principal returns;
  b. A capacity to book the locum 12 months or longer into the future;
  c. That a and b are reliable;
  d. The locum is suitably credentialed;
  e. Ensure that handover before and after the service is provided;
Do you think the government should continue to provide subsidies and programs to assist in providing rural locum medical services? Why or why not?

Summary

Nearly 200 respondents answered this question, with overwhelming agreement that subsidies and programs to assist the provision of rural locum services should be continued.

Respondents particularly noted the role of the programs in supporting rural clinicians to take a break to prevent burnout or enable further study, to address the costs of locum relief, and to aid in retention.

- ‘Yes, locums are an essential part of rural practice, especially as so many rural obstetricians are working excessive hours with little relief.’
- ‘Certainly. Rural practitioners find it difficult to get away and continue to provide cover. Study leave is usually very expensive as there are costs of travel, accommodation, registration, together with keeping the practice open.’
- ‘Yes or medical staff in rural areas will continue to leave these practices as they cannot take adequate leave.’
- ‘Definitely yes. If the rural specialist shortage is to be alleviated and rural communities offered equity of access to care then support is essential.’
- ‘Yes. Otherwise the program will fall over, rural practice will become even less attractive and health of people in rural and remote areas will suffer.’
There are currently a range of locum service providers and programs. Do you believe any one is better placed to provide locum services? If so, why?

Summary
There were 167 responses to this question. Nearly half of the respondents expressed no preference or were unsure whether any locum service provider was better placed than any other to provide services.

Approximately 12% of respondents nominated SOLS. Several respondents identified the program’s link with the Royal Australian and New Zealand College of Obstetrics and Gynaecology as a major benefit.

- ‘SOLS is best placed to serve our needs as it is run through the Royal Australian and New Zealand College of Obstetrics and Gynaecology. They are the most appropriate body to source and management locums related to Specialist Obstetrics and Gynaecology.’
- ‘SOLS is the best in my opinion. It does not have a commercial benefit as the core of the operation.’

Nearly 10% nominated private agencies as their preferred choice for their flexibility and ability to negotiate on behalf of the locum:

- ‘Private providers have flexibility to negotiate best terms and conditions for the locums and as a locum I find this an advantage.
- ‘Private sector more responsive to supply and demand.’
- ‘Requires an experienced private provider for best service.’
- ‘Commercial locum agencies provide a lot more information about the potential locum, without me having to directly contact the hospital involved. I can then determine if I am interested without directly speaking to the doctor advertising for a locum. I have no idea what they wish to pay me and am a bit reluctant to speak to them directly without more information.’

The concept of a centralised agency had appeal for a further 5% of respondents:

- ‘It would be a lot easier for practices if there was one contact that can help with our locum needs rather than having a lot of different options and spending a lot of time dealing with multiple agencies.’
- ‘They should all be rolled into one service that can be contacted. Why have multiple services? Just duplication again. Very frustrating to get the run around all the time.’

Some respondents, however, noted the value of local knowledge:

- ‘Agencies that have good regional knowledge could provide a better service than one nationally based agency.’
- ‘There is a place for some centralisation, but local knowledge application of locums is essential to ensure a good alignment of locums and locations.’

Continued on next page
There are currently a range of locum service providers and programs. Do you believe any one is better placed to provide locum services? If so, why? Continued

State-based locum services were also nominated:

- ‘State workforce agencies are best placed to ensure scarce allocation of resources goes where most needed.’

The Rural Doctors Workforce Agency in South Australia, in particular, was nominated five times by respondents:

- ‘RDWA in SA has a proven track record of excelling in this area.’
- ‘Much as I hate to say it (because of its obvious deficiencies) the most successful service is the RDWASA, which demonstrably is the most successful, maybe because of the additional funding provided by the state, good management by doctors for doctors.’
- ‘The RDWA locum program in SA should be a role model for other services. It is an excellent service.’
Any other comments regarding medical locum services?

Summary

Approximately 100 respondents took the opportunity to make a general comment. These contributions covered a broad span of topics. Approximately one fifth of respondents affirmed the value of the National Rural Locum Program:

- ‘The system works very well, it has been seamless doing my first locum, very warmly received by the docs taking leave and all in the town.’
- ‘They are a necessity for rural practices. We rely heavily on them so that our doctors can have regular much needed breaks without the community suffering.’
- ‘Essential to continuing well being and care of doctors and patients alike.’
- ‘Essential to keep rural practice viable and to provide services to rural communities.’

Many other respondents highlighted areas of improvement or concern. A number of respondents suggested the introduction or extension of various models of locum service provision:

- ‘My experience with SOLS suggests that this model (including government subsidies) could be very usefully applied to all rural medical specialties.’
- ‘Personally I would like to explore the idea of a being a regular locum to the same place ie one week a month with some additional shifts at a local base hospital to keep skills up, but still living where I am settled.’
- ‘An alternative model is to employ salaried locums rather than contractors.’
- ‘The RWAV program for training GPs to work in remote communities is absolutely fantastic. There should be more training programs designed to help urban GPs upskill to take on remote work.’
- ‘Please consider focussing the scheme on sites that require locums services to cover baseline workload and not just leave relief. Any incentive in the market that advantages sites who are better able to recruit permanent staff distorts the market against those sites that require the most locum cover (and not just leave relief).’

This included some support for centralisation of administration:

- ‘A one stop shop would be ideal where practices could find private/public locum agencies and thus be able to find locum services when needed.’
- ‘A national or federal locum agency managed and administered by a newly structured SOLS administration should be set up to operate a nationwide locum service ...’

Continued on next page
Any other comments regarding medical locum services? Continued

Lack of locum availability was of concern for approximately one quarter (8/34) of respondents. Several noted that they had needed to independently locate locums

- ‘For 2½ years we have been unable to get a GP locum. We have ended up finding the locum ourselves and then referring to Health Workforce Qld.’

- ‘Locums are frequently recruited independently to our service by ourselves and other private sector recruitment agencies, and then referred to the schemes to allow access to the subsidy. Unfortunately this requires a significant duplication of paperwork with minimal added quality to our processes. As our service seems to perpetually operate on locums rather than permanent staff and will do for the foreseeable future, it would be more effective to contribute more than a few weeks per year. Perhaps block funding to the most marginal services would be more appropriate than the current system.’

The need for reduction of red tape was a particular concern:

- ‘Removing red tape. Each out of 6 locum placements I have done in last 12/12 required me to submit 20-40 pages application pack — such a waste!’

- ‘Give the subsidy direct to the practice.’

- ‘Streamline the paperwork as well (why does Medicare require the same information on 7 different pieces of paper when a provider number … should ID every doctor, their quals & skills?’

About 12% of respondents raised issues related to the cost of locum services:

- ‘AMA locum and other locum services put % on top of locum earnings which put prices and cost above what a rural practitioner can afford — again just another expense.’

- ‘Currently it is still hard and expensive — I'd wish for a salaried locum pool that we can access at no cost. The Medicare rebates locums attracted are usually barely enough to pay for the running costs of the practice and the salaries of the clerical staff.’

- ‘A good initiative that needs development. Key is a lot of availability and reasonable cost. Locums rarely earn the same as the principal they replace.’

Continued on next page
Any other comments regarding medical locum services, Continued

Summary (Continued)

A further 10% highlighted issues related to the support of or incentives for locums:

- ‘Subsidies to locums for air fares for accompanying spouses is a valued incentive used by at least one provider. Attention to provision of good standard accommodation is important.’
- ‘Can't do it on the cheap if you want highly skilled people who maintain their skills travelling to remote areas … Need good family accommodation otherwise spouses and kids will not support GP to go away to do locums. Have to make it worthwhile for whole family. Ultimately its the wife who gives the okay as to whether I supply a locum slot. Certainly can't stay in dodgy accommodation or vehicles. Need family vehicle.’
- ‘I really appreciate it when I have contact with a locum manager who knows the practice environment I am going to and where I feel supported. Much easier than going in blind.’
- ‘More creative upskilling & learning incentives to be built into plan.’

Other issues raised by small numbers of respondents included the need to address the cost of indemnity cover for locums and concerns about the quality of service provided by private locum agencies.
Method of analysis

Because of the volume and qualitative nature of some of the survey responses (particularly the general questions), the data analysis software NVivo was used to facilitate the analysis. Using NVivo enabled the project team to analyse the data with a high level of rigour and reliability in a short time frame. The process included the following steps:

- Each question was ‘coded’ to identify key themes in the responses
- A ‘coding profile’ was generated for the set of questions in each section of the survey to determine which themes were raised most consistently by respondents.
- A ‘coding report’ was generated for the top themes that emerged in responses to each section of the survey. Representative quotes were then selected from the coding reports to demonstrate respondents’ views about each topic.