

Review of the National Rural Locum Program

Final Report



Prepared by Communio for:

Department of Health and Ageing

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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.

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.

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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, ACCRRM 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.

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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.
