NEW ZEALAND RURAL GENERAL PRACTICE NETWORK

Scoping a nationally coordinated

Rural Hospital Locum Doctor Recruitment Service

May 2021

Contents

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Executive Summary

Background to this Paper

At the Rural Hospital Networks Summits in 2019 and 2020 participants agreed that the urgency to work collaboratively to establish a 'by rural, for rural, in rural' education and training programme to develop a sustainable rural generalist medical, nursing and allied health workforce is their highest priority.

Like other rural health services, on a day-to-day basis, the recruitment and retention of medical staff is one of the biggest challenges facing rural hospitals that participated in the Summits. They also agreed:

- Reliance on locum medical staff to fill rostering gaps results in a disproportionately large investment of their operational time and budget as they work independently to do so.
- The lack of a coordinated approach to recruitment of rural hospital locums impacts on the costs of locum travel and accommodation.
- A coordinated, collaborative national approach is likely to reduce the costs of recruitment and make more effective use of locum medical staff time and availability.

Rural Hospital Network Summit Participants

- Ashburton
- Bay of Islands
- Buller
- Chatham Islands
- Clutha First
- Dannevirke Community
- Dargaville
- Dunstan
- Golden Bay
- Gore
- Hawera
- Hokianga Health
- Kaikoura
- Kaitaia
- Lakes District
- Oamaru
- Taumarunui
- Taupō
- Te Kuiti
- Te Nikau Hospital & Health Centre
- Te Puia
- Thames
- Tokoroa
- Wairoa

The Rural Hospital Summit 2019 report was the catalyst for a meeting between the Rural Hospital Network Executive Committee, the Director-General of Health and some of the Ministry of Health's (the Ministry) senior management team in November 2019. One of the proposals discussed at this meeting was the need to scope a Ministry funded, rural hospital locum medical staff recruitment service which could leverage off the NZ Rural General Practice Network's (the Network) rural health workforce recruitment service much of which is delivered under contract to the Ministry of Health.

In July 2020, the Ministry commissioned the Network, on behalf of the Rural Hospital Network, to undertake the task of scoping the need for a such a recruitment service. A research project into the rural hospital workforce and the role of locum doctors in it, completed by Professor Ross Lawrenson, who is based in Waikato University and DHB, was an important part of this exercise. Professor Lawrenson's report is referenced throughout this document.

Purpose

This report will enable key stakeholders to improve their understanding of the pressures that rural hospitals face in maintaining their medical workforce and the variable approaches they take to doing so.

This report provides:

1. A definition of rural hospitals that could inform eligibility to access a national rural hospital locum doctor recruitment service.
2. Information about the rural hospital medical workforce – permanent and locum.
3. Information about how rural hospitals currently recruit locum medical staff and the associated costs.
4. An assessment of the extent to which a rural hospital locum recruitment service could leverage off NZLocums current infrastructure and expertise in recruitment of the rural health workforce.

This report is not a business case for the development and delivery of a nationally coordinated rural hospital locum doctor recruitment service but discusses how this could be done, and the potential impact of it.

The Process Applied to Preparing This Report

The Network has undertaken a widely consultative process to the preparation of this report:

- 'Rural Hospital Workforce Survey Report 2020' Professor Ross Lawrenson (Appendix 1)
- Workshop with Rural Hospital Summit participants from 21 rural hospitals

- Consultation and advice from the Rural Hospital Network Executive Committee
- Consultation and advice from NZLocums team
- RGPN meetings and visits to rural hospitals across NZ.

Summary of Key Points Made in Each Section of this Report

1. Defining Rural Hospitals

- The DRHM definition of rural hospitals provides a platform for eligibility for a nationally coordinated locum recruitment service.
- The scope of rural hospital services and categories of inpatient beds indicates the high level of rural generalist skill and expertise required across its medical workforce.
- Rural hospital ownership and operational models vary greatly. This has an impact on options available to them in recruitment of medical staff and meeting their locum doctor requirements.

2. Some Features of The Rural Hospital Medical Workforce – Permanent And Locum

- The shortage of NZ trained RHM doctors significantly impacts on rural hospitals need to fill gaps in rosters with locum doctors.
- Hospitals provide clinical leadership for their medical staff. Credentialling of doctors is also an operational function of most rural hospitals. These two factors may contribute to the clinical viability of a nationally coordinated recruitment service.
- Recruitment of IMG locums is likely to require clinical oversight to ensure candidates are appropriately qualified and have the experience required to work in the NZ rural hospital setting.
- The locum doctor workforce has a critical role to play in reducing the levels of burnout in the rural health workforce.

3. The locum doctor workforce, approaches, costs and impacts

- There is a dearth of NZ information about the financial cost to the health sector of rural hospital locum doctors including locum fees, travel and accommodation, and recruitment costs. Assumptions are that this is in excess of the cost of employing a permanent SMO, but given the flexibility this workforce offers, these assumptions may not be valid.
- Locum fee rates, for planned placements are relatively consistent across NZ. Recruitment service fees are also consistent at 15% of the locum fee.
- There is variability of the extent to which rural hospitals use recruitment services, largely due to the considerable cost this adds to filling a gap in a hospital roster.
- The rapid development of virtual consultation services may be an important component in rural hospital locum services of the future.

4. Recruiting Rural Hospital Locum Doctors

- The direct costs of recruiting rural hospital locums are not identifiable, as in many organisations they are incorporated in administrative and managerial accounting codes.
- The direct cost of rural hospital locum doctors is not nationally identifiable as many accounting practices do not identify this as a separate item of expenditure from permanent staff.
- A nationally coordinated pool of rural hospital locum doctors, rostered over a 12-month period, across participating hospitals is likely to provide financial and logistical benefits to both the hospitals and the locum workforce.
- An urgent locum service, that is well resourced, would reduce the drain on rural hospital operational resources and contain the escalating costs of locum services.
- The Framework for rural hospitals rostering of locum doctors provides a platform from which the Network NZLocums management have assessed the ability to leverage of their current service models to establish a nationally coordinated rural hospital locum doctor service.

5. Leveraging a Rural Hospital Locums Service Against NZLocums Existing Services

- Critical success factors of a nationally provided rural hospital locum recruitment service include:

- Effective relationships with rural hospitals and the communities in which they work.
- Excellent relationships with Medical Council NZ (MCNZ) and Immigration NZ.
- Comprehensive knowledge and experience in working with MCNZ and Immigration policy requirements.
- NZ clinical / academic oversight of candidate selection.
- A rural hospital three-day Orientation Programme for IMGs arriving in NZ.
- A cost-effective international recruitment campaign.
- A whanau approach to recruitment that meets short term needs but aims for long term outcomes.
- Realistic goals for placing international candidates that reflect recruitment lead-in times.

6. The Development of a National Rural Hospital Locum Recruitment Service

- There are four levels of locum service response that would be required to deliver a national rural hospital locum doctor recruitment service:
  - Urgent 1-7 days
  - Planned 7 days – 6 months
  - Long term 6 – 12 months
  - Permanent Over 12 months
- NZLocums would require three years to establish a reliable and sustainable service that optimises technology, has a pool of NZ based and international locum doctors, has given rural hospitals time to adapt their current processes to move to a national recruitment service, and can credibly contract for future services on a volume basis.
- There is a sector wide advantages both clinical and financial of a nationally coordinated rural hospital locum service.
- The Rural Hospital Workforce Survey Report, 2020 has made a significant contribution to both the Rural Hospital Network and the Network's preparation of this report.

Conclusions

The Network draws the following conclusions from the information in this report:

- Rural hospitals are reliant on a robust and accessible locum doctor workforce in order to maintain rosters, and sustainable levels of service for their communities.
- Rural hospitals take a range of approaches to meeting their needs for locum doctors. Many of these are an inefficient in the use of staff time, place pressure on permanent medical staff, and escalate the costs of locum services.
- It will take two-three years to establish the service to the equivalent level of performance and sustainability of NZLocums rural general practice locum service.
- A nationally coordinated, rural hospital locum doctor recruitment service is likely to provide a range of benefits to:
  1. Rural hospitals:
     - Increased access to a pool of approved locum doctors
     - Reduced management time in sourcing locum doctors – planned and unplanned
     - Potential to contain the costs of recruitment fees, and locum fees
     - Reduced pressure on permanent medical staff to fill gaps in rosters or respond to afterhours call outs.
  2. Rural hospital locums:
     - Increased ability to plan locum shifts, and decide when and where to work
     - Ability to work with a centralised recruitment service that specialises in rural hospital needs
     - Confidence in IMG locum colleagues that have been recruited to the NZ rural hospital network.
  3. The rural hospital workforce:
     - Increased ease to work as a rural hospital locum doctor
     - Reduced burn out of permanent hospital doctors as locums are more readily available

- Confidence in the 'readiness' of internationally recruited IMGs to work as locums in the rural hospital setting.

Recommendations

The NZ Rural General Practice Network recommends that the Ministry of Health Workforce Directorate:

- Continues to prioritise the development of a sustainable rural health workforce that encompasses medical, nursing and allied health services. It includes:
    - A nationally dispersed education and training programme embedded in rural hospital and general practice
    - Emphasises registrar training that is broadly distributed around rural hospitals;
    - A credentialing in system for medical staff working in rural hospitals, with a complementary training programme to upskill where gaps exist
    - An orientation programme for rural hospital doctors that is consistent in nature and nationally coordinated. Also, for each rural hospital to have a complementary orientation programme specific to their location;
- Develops and implements a nationally coordinated recruitment and locum service for rural hospital medical staff to both support the recruitment of permanent staff and manage the coordination of locum medical staff and,
- Discusses the potential to enter into a three-year contract with NZ Rural General Practice Network for the development and delivery of a nationally coordinated, rural hospital locum doctor service. The development of such as service could be based on:
    - Two full time recruitment staff members
    - A funded programme of service development outlined in table 3,4 & 5
    - Regular review and monitoring of the service development.

1. Defining Rural Hospitals

Division of Rural Hospital Medicine: Definition of a Rural Hospital, 2010:

A rural hospital is a non-metropolitan hospital staffed by suitably trained and experienced generalists, who take full responsibility for a wide range of clinical presentations. While resident specialists may also work in these hospitals, cover is limited in scope to less than full time. There are three levels that the 33 rural hospitals are grouped in:

1. Visiting medical cover once a day, with on call medical cover at other times.
2. Onsite medical cover during normal working hours – on call medical cover at other times.
3. Onsite 24-hour medical cover.

Level 1:	Whangaroa (Kaeo), Te Aroha, Morrinsville, Ōpotiki, Te Puia Springs, Stratford, Taihape, Kaikoura, Maniototo, Chatham Islands
Level 2:	Hokianga, Dargaville, Matamata, Te Kuiti, Dannevirke, Takaka, Buller, Reefton, Gore, Balclutha
Level 3:	Kaitaia, Thames, Tokoroa, Taumaranui, Hawera, Greymouth, Ashburton, Oamaru, Lakes District, Dunstan

The Ministry of Health Workforce Directorate recognises this definition of rural hospitals in its funding of Division of Rural Hospital Medicine (DRHM) places. Therefore, the DRHM definition could provide a platform for eligibility to a nationally coordinated rural hospital locum service.

As a general rule, a rural hospital offers urgent, acute and maternity care without continued input of specialist medical practitioners. Some of the larger rurally facing hospitals that provide secondary care services are leaning toward the rural generalist model e.g. Te Nikau Hospital and Health Centre (previously known as Grey Base Hospital) and Ashburton Hospital.

The Rural Hospital Workforce Survey Report, 2020 (the Survey Report) identifies 24 hospitals across the 3 levels of the DRHM definition that are relevant to the survey.[i]

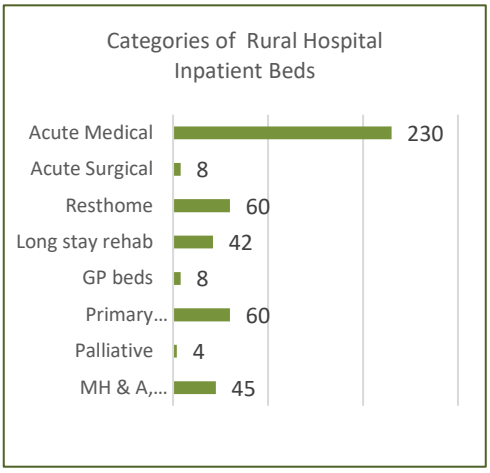

Figure 1 The Survey Report, Table 2

Of those, 18 hospitals provided full survey responses from either, and in some cases both, managers and clinical directors. Others were interviewed by the research team, many of them contributed to the workshop discussion facilitated by the researchers at the Rural Hospital Network Summit in September 2020, some also provided specific information in discussions with the Network for the purposes of this study.

The Survey Report also identified the range of services, and categories of inpatient beds provided in respondent hospitals.[ii] This information provides a high-level indicator of the range of skills a rural hospital requires in its medical workforce, including locum staff.

Rural Hospital Ownership and Operational Models

There are considerable differences in the ownership and operational models of rural hospitals.

- Owned and operated by a DHB e.g., Dargaville, Kaitaia, Thames, Tokoroa, Taumaranui, Hawera, Greymouth, Ashburton, Lakes District
- And, in partnership with a primary care practice e.g., Te Kuiti, Buller, Wairoa, Greymouth
- Community or iwi-based NGOs that provide hospital services under contract with their DHB e.g., Dunstan, Oamaru

- And some of these also provide primary care services e.g., Te Puia, Hokianga, Dannevirke, Balclutha, Kaikoura, Gore, Takaka, Chatham Islands

The ownership model has some influence over a hospitals approach to the recruitment of medical staff including locums. This will be discussed in more detail later.

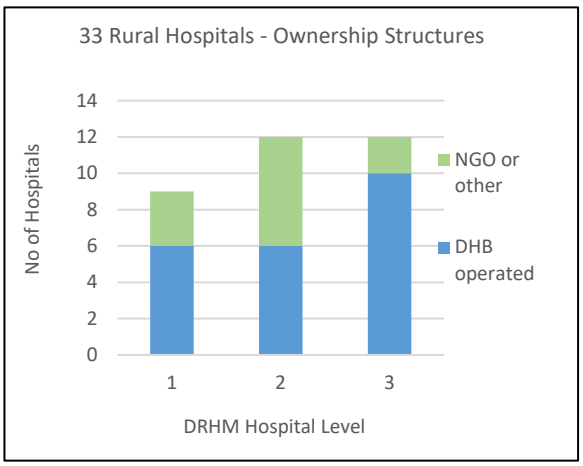

Figure 2 Rural Hospital ownership structures

Key points:

- The DRHM definition of rural hospitals provides a platform for eligibility for a nationally coordinated locum recruitment service.
- The scope of rural hospital services and categories of inpatient beds indicates the high level of rural generalist skill and expertise required across its medical workforce.
- Rural hospital ownership and operational models vary greatly. This has an impact on options available to them in recruitment of medical staff and meeting their locum doctor requirements.

2. Some Features of The Rural Hospital Medical Workforce – Permanent And Locum

There are about 150 doctors employed across both DHB and non-DHB rural hospitals with roughly half employed in each (49% non-DHB and 51% DHB employed).[iii] More detailed analysis is required to account for overlaps, locums and employment details such as:

1. The number of doctors who work in both a DHB's main hospitals and its rural hospitals (Waikato hospitals are an example of where this happens)
2. The number of doctors that work across a rural hospital that is integrated with a primary care service (Te Kuiti, Wairoa, and Buller are some examples of this).

The rural hospital workforce is heavily impacted by the rural health workforce crisis. The Survey Report identified that 35% of responding hospitals experience a shortage of medical staff and an additional 35% said they experience a serious shortage of medical staff – 70% in total. This is similar to the levels reported in the 2014 Rural Hospital Doctors Workforce Survey[iv].

Many respondents said that while they may not be fully staffed, their workforce is mostly stable. But they also said that they can have difficulties in covering CME, study, annual and sick leave for their permanent staff. In these situations, they can be reliant on locum doctors to fill gaps in rosters.

Clinical Leadership and Supervision

Of doctors who responded to the Survey Report's survey 93% reported the presence of a Clinical Director and 86.7% of these work in the same hospital. [vi] 76.4% of rural hospitals credential their medical staff – either through a DHB credentialling committee or a Chief Medical Officer.

This nationally consistent approach to embedding clinical leadership in rural hospitals could be an enabler of a national rural hospital locum doctor recruitment service. This would be particularly so for IMGs who may be on their first rotation of working in a rural hospital in NZ, or a NZ doctor who is new to a particular hospital. It would also contribute reducing the impact of locums on the continuity of a patients care and the disruption to the hospital staff who induct and supervise new locums.

Characteristics of Rural Hospital Doctors[vii]

Most Survey Report respondents said that while their rural hospital doctors are employed as permanent staff 46.7% of them are part time. They were not asked to provide reasons for their decision to work part time but

anecdotally includes the flexibility that working as a locum gives to work hours, a variety of hospitals to work in, and higher rates of pay than permanent positions, as contributing factors.

Most respondents live within 50Km of the hospital where they work but 30% of them live more than 50Km from their place of work. This suggests that most doctors who contribute to a rural hospital's pool of regular locums, do so within reasonably close proximity to where they live.

Rural Hospital Service Demand and its Impact on the Rural Medical Workforce

ED patients in 10 L2 & L3 Rural Hospitals in the year to 30 June 2020	
# Rural Hospitals	10
# ED patients	98463
# FTE Drs	78.2
Ave Presentations per FTE	1260

The range of services and clinical models in rural hospitals vary greatly. In rural health the boundaries between hospital and community services vary considerably from service to service, and the boundary is often (appropriately) very blurred . Examples of these are discussed in the ASMS Rural-Generalism paper. [i] Urgent and primary care afterhours care has increasingly become a core business of rural hospitals as rural general practices struggle to maintain an afterhours roster.

This lack of clarity is probably why there was considerable variability in the way in way in which respondents replied to the survey. This includes what constitutes a medical FTE (e.g does it include registrars / house officers / local primary care) or what constitutes an ED visit (does it include afterhours primary care). For these reasons it is important the data is not used to make comparisons between hospitals.

There are several examples where this is a planned and funded agreement (Te Kuiti, Wairoa) and others in which this is occurring by stealth and without the funding to support this. The increased integration of rural general practice and rural hospital services, and the need for flexible models across acute, ambulatory, and urgent care needs directly impacts on the medical skills and experience needed in a locum workforce.

Not all Survey Report respondents provided data about the number and nature of ED presentations, but the information shown in Table 2 may be indicative of a national trend. Respondent hospitals endorsed this in their identification of the skills and qualities they look for in a locum doctor:[viii]

- Preferably RHMS, FACEM
- RMOs with recent experience in ED and rural hospitals who can work independently across the scope and high volume of emergency presentations
- Must be flexible in scope of practice – comfortable managing inpatients, and prepared for maternal and neonatal resuscitation and able to cover family medicine
- Have skills and awareness in relation to resource management
- Whanau friendly and a team player.

The demand for emergency and urgent care services in rural hospitals not only impacts on the skills and experience of doctors, but also on how a hospital rosters locum doctors (table 3). As there is a greater pool of emergency consultant locums, there is a high level of commonality in protocols across all hospital emergency departments which enhances the transferability of these skills across all hospitals. The rural generalist skills required for the inpatient service can be more difficult to source in locum doctors.

Shuffling the team

Several Rural Hospitals have a busy ED department alongside inpatient beds. Several have a co-located General Practice. Many of their permanent staff doctors are Rural Hospital and Rural General Practice specialists.
When they to roster locum doctors, they seek Emergency Care Specialists for their A & E department and shuffle permanent doctors across the GP and inpatient service. There a several reasons for this:

- There is a larger pool of Emergency Consultant locums than RHMs.
- There are consistent protocols across hospital EDs which enhances a doctor's ability to work across them
- The RHM doctor who moves from A&E into the inpatient ward enables continuity of care rural generalist skills.

Comment:
This approach reflects the how important the rural generalist model is to rural hospitals. It also suggests that a national rural hospital locum service could recruit doctors from a wide range of medical expertise and qualifications.

The qualifications of the doctors contributed to the Survey Report shows the positive contribution the DRHM specialty has made to this critical workforce. 76.7% of respondent doctors scope of registration was both Rural Hospital Medicine and General Practice. It also reflects the broad concept of rural generalism in NZ that led to the establishment of the Division of Rural Hospital Medicine in NZ.

Burnout of rural hospital doctors

The Association of Salaried Medical Specialists (ASMS) Health Dialogue - Burnout[ix] identified that doctors working in General Practice and Rural Hospital Medicine had the highest prevalence scores for patient related burn-out across all specialities. The study did not breakdown rural and urban general practice and so this data only implies an association between these specialities in the rural service setting. Personal examples given to the Network in discussions with rural hospital doctors (both GP and RHM) suggests there is a valid association between rurality and the ASMS reported statistics.

The RNZCGP 2020 Workforce Survey[x] also asked RHM respondents to assess the level of burnout that they experience. Over one-quarter of respondents working or training in rural hospital medicine rated themselves as being burnt out to some extent, which was a level lower than reported in previous studies.

Data that contributed to both of these reports has not been cross matched and so it is not clear if each study collected information from the same individual doctors, or if across them, they reached quite a large number of doctors in total. However, both reports indicate that there are pockets of extreme pressure on the RHM workforce.

A highly respected DRHM doctor shared his story for this report:

"I have worked for many years across both our rural hospital and General Practice service. We have always struggled to maintain a full team of doctors, so rosters have always been a challenge. DHB management seem to have given up on even trying to secure locum doctors which results in immense pressure on us to fill gaps. It is not uncommon for me to start a GP day on a Friday at 8am, go through to hospital rosters from Friday at 8pm until 8am on Monday morning, then return to the GP service for another full day of consultations – finishing finally at 5pm. That's 64 hours on duty and on call.

I've been in a consultation with a patient on Monday afternoon on the final run of this sort of shift and nodded off at my computer – clinical safety completely compromised, my family furious at me for letting them down – again – and I'm absolutely exhausted.

Why? Well the cost of having a locum fill the weekend rosters, at around $5000 for a weekend day, as opposed to paying permanent staff on a much lower rate of $500 per session and a lower afterhours call out rate, has a massive influence on this especially when the DHB is running at such large deficits."

Comment:

It is generally understood that a large number of doctors who work in rural health services experience burnout. This is just one example of this in a rural hospital setting. The challenges of recruiting either permanent or locum doctors alongside relentless demand from rural communities seeking both urgent and inpatient care, leaves service management with few options other than to ask their permanent staff to fill gaps in rosters.

The Kaitaia Hospital Accident and Emergency trial (detailed in Table 2) shows the opportunities that telehealth consultations could offer rural hospitals struggling with gaps in medical staff. The example shows how virtual emergency specialist consultations can support a nurse only service where in-person options are limited and reduce burnout in RHM doctors.

Key points:

- The shortage of NZ trained RHM doctors significantly impacts on rural hospitals need to fill gaps in rosters with locum doctors.
- Hospitals provide clinical leadership for their medical staff. Credentialling of doctors is also an operational function of most rural hospitals. These two factors may contribute to the clinical viability of a nationally coordinated recruitment service.
- Recruitment of IMG locums is likely to require clinical oversight to ensure candidates are appropriately qualified and have the experience required to work in the NZ rural hospital setting.
- The locum doctor workforce has a critical role to play in reducing the levels of burnout in the rural health workforce.

3. The Locum Doctor workforce, approaches, costs and impacts

The Royal Australasian College of Medical Administrators (RACMA) published its review of the cost effectiveness of locum doctors in New South Wales [xi]. The study investigated the long-held view that the cost of locum medical staff incurs disproportionately higher costs than that of a full staff of permanent doctors. While the study's financial analysis is specific to the state of New South Wales, and there is a significant variance in the medical salaries in each country, the key findings may have some relevance to the NZ rural hospital environment:

- Locum staff costs including fees and the costs of travel and accommodation, may be in line with the full cost of employing a permanent Senior Medical Office (SMO) once all leave entitlements and the cost of maintaining professional competencies are taken into account.

  This might imply that there are reasons to continue to support a robust rural hospital locum workforce as the overall cost of one approach over the other may be cost neutral in a fully staffed rural hospital.
- The direct cost an either/or approach may be less important than the indirect cost of a disruptive staffing model on both clinical and managerial staff as they recruit, induct and train locum staff, on the continuity of care for the patient, and the community's confidence in the hospital service.

The Cost of Locum Doctors

There is a clear link between a hospitals ability to forward plan to include locum doctors in their rostering cycle, and the cost to the hospital of doing so. If the costs of locum doctors are contained through minimized recruitment costs, and planned inclusion in rosters, the marginal cost of locums compared to the cost of a full-time medical staff member may be less than the sector assumes.

The mobile, skilled rural hospital locum workforce makes a significant contribution to the long-term sustainability of rural hospitals and if the RACMA findings are also true in NZ, may be at a comparable cost to a permanent rural hospital workforce if reactive costs as recruitment fees and urgent travel can be contained.

Due to a range of issues including variations in DHB accounting and reporting systems, and different approaches to allocating budgets, we cannot quantify the actual cost of locum doctor services with any level of confidence. However, there appears to be consensus about the rates paid to locum doctors when there is adequate time to plan for them doing shifts. But equally, the escalated cost of short-notice locums also appeared to have some consistency. The range of locum rates told to the Network across numerous hospitals, in April 2020 are:

- Day shifts: $1300 - $1600
- Night shifts: $900 - $1400
- Or: $200 per hour, and, often
- For both the shift fee or hourly rate, there can be additional call out charges - $400 + $40 per hour.

This Rural Hospital is integrated with a primary care service that provides afterhours and hospital services weekdays. It relies on locum doctors for all weekend shifts.

Most weekend shifts are filled with regular pool of locum doctors. I not, the hospital has 2 options:

1. Negotiate with the primary care service GPs to work extended hours to cover the hospital weekend services. Rural Hospital B pays their own GPs the same rate as the regular locums if they work over the weekend in the hospital.
2. Canvas DHB doctors to fill weekend roster gaps.

Weekend locum costs (8am Sat – 8am Mon)		
	Regular locums/ or inhouse GPs	Unplanned Locums
Night shift	$1300 p/shift $2600 p/we	$200 p/hr 4800
Day shift	$1400 p/shift 2800 p/we	$200 p/hr4800
W/E Locum fee	**$5400**	**$9600**

Comment:
This example was provided for this report. It shows how the ability to plan for locum doctors will reduced the cost of the locum to the service.

The figures provided in this example are consistent with those provided in discussions with many other rural hospitals. Most indicated that the hourly rate for a locum doctor is $200, with additional costs for call outs overnight.

Some hospitals said that over and above the nightshift rate, if called out, there is an additional $400 call out fee and additional $40 per hour. The higher cost of unplanned locums was also common.

Table 1 An example of the cost of locum doctors in a rural hospital

Recruitment Fees and Other Additional Costs of Locum Doctors

While the hospitals that responded to the survey or provided direct information spoke of their reliance on recruitment agencies in sourcing locum doctors, they were equally scathing about the fees charged for doing so. The fees charged by recruitment agencies seem consistent at 15% of the locum fee.

Using the example of the costs of locums to a rural hospital (table 4) and if they plan in advance for locum cover, the recruitment fee would incur an additional $810 to the cost of the weekend roster. If the hospital sources a locum at short notice, the recruitment fee just for the weekend will be as high as $1440.

In the example given in Table 1, the addition of a recruitment fee for an unplanned locum, and say, $500 for the cost of their travel, the weekend locum can cost the hospital in the vicinity of $11500.

There are additional costs to include in these calculations because while the Survey Report shows that many rural hospital locum doctors live close to where they work, many travel long distances for relatively short placements e.g., a weekend. The high cost of short notice airfares to regional centres such as Westport, Kerikeri, and Gisborne and the logistical challenges caused by few flights into these centres negatively impacts on the efficacy of both the doctors time, and the total cost of the locum to the rural hospital.

Virtual and telehealth services rapidly developing capacity to provide acute clinical consultations in a wider range of settings. A trial of this between the Kaitaia Hospital ED and a private provider, Emergency Consult, was presented to a large audience at the National Rural Health Conference April 2021. It generated supportive and engaged discussions about how services like this might provide virtual clinical support for rural hospitals. There is potential for this type of service to be a component of a nationally coordinated rural hospital locum service, particularly for urgent requests for a locum.

Kaitaia Hospital Accident & Emergency Unit

3-month trial of virtual Emergency Consultations

Staff at Kaitaia Hospital and the Emergency Consult Service Provider presented the results of their 3 months of trialling virtual Emergency Consultations at the National Rural Health Conference 2021.

An extreme shortage of doctors led the hospital service to having overnight SMO for higher acuity patients and nurse led with and on-call GPs from 2200-0800 each day for triage 4 and 5.

Their 3-month trial of using virtual Emergency Consultations with doctors to support the ED service (FACEMs) produced encouraging results. The presentation was well received with rural hospital doctors commenting that this was certainly a viable option for addressing gaps in their own afterhours hospital rosters.

Over 8 weeks of data that was collected in the trial:

- 224 ED presentations
- 40% of these were 'seen' by the virtual Emergency Consultant.
- 73% of these were treated and discharged.
- A review of each case found that there would have been no difference in outcome if the EC was done 'in person'.
- 85% of patients said they did not mind speaking to the EC on 'TV'.
- All patients said the doctor had met their needs to their satisfaction.
- Hospital nursing staff felt more comfortable being the

Table 2 Presentation at the NRHC 2021, by Kaitaia Hospital ED Staff and Emergency Consult, Martyn Harvey

Key points:

- There is a dearth of NZ information about the financial cost to the health sector of rural hospital locum doctors including locum fees, travel and accommodation, and recruitment costs. Assumptions are that this is in excess of the cost of employing a permanent SMO, but given the flexibility this workforce offers, these assumptions may not be accurate.
- Locum fee rates, for planned placements are relatively consistent across NZ. Recruitment service fees are also consistent at 15% of the locum fee.
- There is variability of the extent to which rural hospitals use a recruitment services, largely due to the considerable cost this adds to filling a gap in a hospital roster.
- The rapid development of virtual consultation services may be an important component in rural hospital locum services of the future.

4. Recruiting Rural Hospital Locum Doctors

As unique as each rural community, and the rural hospital that cares for it, is the approach taken to filling the hospitals rosters for medical staff.

That the rural hospital sector is in dire need of support to establish a sustainable source of locum doctors, is agreed by all those involved in the Survey Report, and the work done across the Rural Hospital Network, and RGPN for this report.

The challenge has been to capture the many different ways that rural hospitals have developed to ensuring they have the medical staff required to meet the clinical requirements of their service and optimise the outcomes for each and every person who comes into their care, either as an urgent presentation, or through an inpatient admission.

In the next section of this document, the rural hospital network has created a Framework for the way rural hospitals currently roster locum doctors. It considers the impact of each approach or situation on not only the hospital itself, but also the doctors that work in it, both permanent and locum, the other services is works with, and most importantly, the whānau and patients in their care.

The Framework is not lineal. A hospital may slide across approaches as staff come and go and demand for services change. The features of each approach are equally fluid.

The Framework provides a strong foundation upon which the Networks NZLocums team have assessed the ability to leverage off the services they currently provide for rural general practices under contract to the Ministry of Health, to develop a similar resource for rural hospitals.

Framework for Rural Hospitals Rostering Locum Doctors

NB Approaches, their features and impacts are not lineal or permanent. A hospital will move between them as their medical staffing configurations change in the usual course of business

Approach 1

Features

- The number of medical FTEs employed by the hospital covers planned leave requirements: education, annual leave, and sick leave.
- Rosters accommodate a lot of the planned leave and have capacity to manage most unplanned short term leave through staff rostering. However, locums are needed when staff want the same time off, or for planned extended leave such as sabbatical cover.
- Locum medical staff are needed for urgent situations or illness that causes an unplanned staff shortage.

Cost implications for the hospital	Impact on the hospitals own service continuity and on other health services	Clinical & Mgmt time needed to do rosters	Locum doctors	Impact on providers own staff	Patient & Community Experience	Benefits of a national locum service
Upfront FTE costs may be assumed to be more costly than other approaches. A robust comparison of this approach against others that are more reliant on locum doctors may dispel this view.	Consistency in referrals and transfers to base hospitals. Urgent care presentations at base hospital are consistent. Enables other services to plan and budget for transfers or referrals.	Consistency in rostering permanent staff reduces the time needed to do this. Urgent sourcing of locums is the exception rather than the norm.	May be from a regular pool, locum doctors are supported by permanent staff.	Consistent rate of work, enhances the hospital's ability to recruit and retain medical workforce.	A reliable service that is close to home, easy to access. Community and other health providers have a high level of confidence in the service.	Support to source unplanned or urgent locums.

Approach 2

Features

- The rural hospital uses a configuration of permanent staff and locums e.g.:
  - The hospital plans for permanent staff to be rostered on weekdays with locums rostered over weekends – this is particularly the case for hospitals that also have a primary care service attached.
  - The hospital may be unable to fully staff its service and so has a level of permanent staff that is less than needed for a full roster and fills roster gaps with locum doctors.
- Hospitals adopt a **tiered approach** to filling weekly roster or meet staff leave requirements:
  1. Offer extra shifts to permanent staff members, many of whom are not full time.
  2. The hospital's regular pool of locums
  3. Use DHB wide locum networks and/or external recruitment agencies.
  4. 'Stretch' existing staff capacity to fill roster gaps.

Cost implications for the hospital	Impact on the hospitals own service continuity and on other health services	Clinical & Mgmt time needed to do rosters	Locum doctors	Impact on providers own staff	Patient & Community Experience	Impact of a national locum service
This approach can help contain the cost of locum doctors. A hospital that frequently functions at 'tier 4' places a burden on its own staff to fill rosters as it is less expensive than paying higher locum fees. DHB hospitals do not always attribute the increased cost of locums directly to the service, so the annual costs of locum doctors are not reported. In NGO hospitals, the financial impact of a tiered approach is more easily identified. Some hospital managers advise that the financial burden of levels 2 and 3 place a significant drain on the financial sustainability of the service.	For those hospitals with a strong pool of locum doctors, service delivery is consistent. For those that are more reliant on Tier levels 2, there is greater fluctuation in referrals and transfers to base hospital. Increased transfers to base hospitals have a significant impact on whānau and patient outcomes, logistical and financial stresses and overall, wellbeing.	Varies, depending on the success in filling rosters at Tier 1 or 2.	A locum doctor that regularly works in a rural hospital is able to plan ahead for this. But they may not be able to easily identify opportunities to work in other hospitals on a less regular basis.	Many permanently employed hospital doctors work part time and often additional shifts that suit. However, senior doctors told the Network that when the hospitals requests that they do additional shifts become excessive, (tier 4) they feel under pressure to accept untenable rosters for long periods of time. There is a significant impact on their wellbeing, for a large number this escalates to burnout, and concerns that their clinical judgement is impaired by burnout.	Patients are usually seen by highly qualified doctors, but if the rosters are filled with permanent staff doing extra shifts to help out, then the clinical risk escalates. Community has confidence in the service.	Improves: • Hospital access to a wider pool of locums. • Clinical safety • Coordination of locums that work across more than one hospital. • May neutralize the excessive costs of some locum shifts. Reduces SMO burnout and risks to clinical safety. Efficient method of advertising and filling locum shifts.

Approach 3

Features

- This approach is similar to Approach 2, but the DHB operated Rural Hospitals rely more heavily on a combination of their own permanent staff to do extra shifts or ask staff in the DHBs other hospitals to travel to their other hospitals to cover gaps in rosters.
- The costs of sourcing locums through recruitment agencies is a significant barrier as hospitals endeavor to contain budgets and/or DHB deficits.

Cost implications for the hospital	Impact on the hospitals own service continuity and on other health services	Clinical & management time filling rosters	Locum Doctors	Impact on providers own staff	Patient & community experience	Impact of a nationally dispersed locum service
The rural hospital medical staff budget may be appeared to have met but the impact on permanent staff who travel to another hospital to cover the roster gaps, or some who are working extended hours is not measured. The cost of locums is often higher than the cost of getting permanent staff to fill roster gaps but DHB wide systems does not provide accountability for this.	Can lead to rostering doctors who may not be ideally qualified for the locum placement. It can increase pressure on base hospital and A&E services, increases air and road ambulance transfers which in turn impacts on their capacity to respond to emergency callouts. Ongoing reliance on locum medical staff leads to difficulties in recruiting either permanent or locum doctors as to quote a highly experienced SMO: "no one wants to go somewhere that is so unsupported."	Large, unrecorded amount of staff time sourcing locums. Stress increases as the roster gaps near e.g., late on Friday afternoon for a weekend. Places pressure on permanent clinical staff to do extra shifts to fill gaps in rosters.	May not be planned in advance and the locum is often arranged at short notice. The locum may feel clinically unsupported.	Heavy impact on hospital or DHB permanent staff who feel pressured to fill gaps in rosters. Some SMOs told the Network that requests they do additional shifts can become excessive, and they feel pressured to accept untenable rosters for long periods of time. They spoke of a significant impact on their wellbeing, and concerns their clinical judgement is impaired by burnout.	Increased transfers to base hospitals significantly impact whānau and patient outcomes, and the personal and financial cost of seeking health services. Community experiences fluctuations in service capacity. Hospitals develop a reputation for being unreliable and community links this to poorer clinical standards.	Improves: • Hospital access to a wider pool of locums. • Coordination of locums that work across more than one hospital. • May neutralize the excessive costs of some locum shifts. Reduces SMO burnout and risks to clinical safety. Efficient method of advertising and filling locum shifts.

Approach 4

Features

- The rural hospital is unable to maintain a full permanent medical team, and unable to maintain a regular pool of 'casual medical staff' and is not able to easily access DHB Hospital doctors as locum support

Cost implications for the hospital	Impact on the hospitals own service continuity and on other health services	Clinical & Mgmt time filling rosters	Locum doctors	Impact on providers own staff	Patient & Community Experience	Impact of a nationally dispersed locum service
The hospital has an unallocated medical budget as positions remain unfilled for long periods of time.	Increased pressure on base hospital and A&E services Increases air and road ambulance transfers which in turn impacts on their capacity to respond to emergency callouts. Increased transfers to base hospitals has a significant impact on whanau and patient outcomes, logistical and financial stresses and overall, wellbeing. Ongoing reliance on locum medical staff leads to difficulties in recruiting either permanent or locum doctors.	Large, unrecorded amount of staff time sourcing locums. Stress increases as the roster gaps near e.g., late on Friday afternoon for a weekend. Places pressure on permanent clinical staff to do extra shifts to fill gaps in rosters.	Locum may feel clinically unsupported, working in isolation.	Non-medical staff work beyond their 'comfort zone'.	Increased transfers to base hospitals significantly impacts whānau and patient outcomes, and the personal and financial cost of seeking health services. Community experiences fluctuations in service capacity. Hospitals develop a reputation for being unreliable and community links this to poorer clinical standards.	Rural hospital locum 'hot spots' are more visible to locum doctors. Increase rural hospital's ability to connect with a wide pool of locum doctors.

Sourcing And Rostering Locum Doctors

About half of the Survey Report respondents noted the shortage of rural hospital locum doctors.[xii] They also said they have a network of locum doctors that they roster on a regular basis. Given the relatively small pool of locum rural hospital doctors across NZ, it is likely that there are significant overlaps between their networks. The part-time employment arrangements of nearly half of the doctors who responded to the survey also builds capacity with the hospitals they work for to roster planned and often, urgent locums.

Survey Report respondents were unable to quantify the amount of time hospital staff spent in sourcing locums to fill planned or unplanned gaps in their clinical rosters. However, many of them frequently discuss the relentless pressure on their time and energy in this regard.

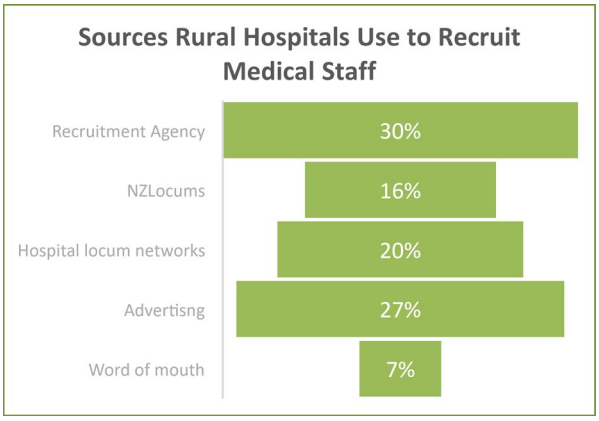

Figure 3 Rural Hospitals Recruitment of Medical Staff

The coordination of a national pool of rural hospital locums could significantly enhance rural hospital workforce planning and efficiencies for all stakeholders. A transparent system that connects the rural hospitals seeking to fill gaps in their medical rosters, with a nationally dispersed pool of locum doctors together could enhance forward planning and have the ability to respond to urgent locum placements. It is likely to have both financial and logistical benefits to both the rural hospitals and the locum doctors.

Resources, Costs, and Pressures Associated with Recruiting Locum Doctors

Neither the Survey Report responses or other information provided to the Network for this report was adequate to establish the cost to the NZ health system of recruitment, session fees, and other expenses such as travel and accommodation of the rural hospital locum workforce.

Some reasons for this include:

- Locum fees are embedded in the DHB or hospitals salary budgets and are not readily identifiable as a specific expense.
- The actual cost of recruitment is only identified when an external agency is contracted to do this. The costs of hospital staff time involved in filling locum shifts, both planned and urgent, are not reported.

Survey respondents indicated that there is little international recruitment of locum doctors as the costs of doing so are outweighed by the short-term nature of locum services.

Rural Hospital Summit attendees describe the frequent loss of Friday afternoons as they rush to ensure locum cover for weekends. They describe the time consuming and frustrating lengths they go to including phoning all of their locum contacts, emailing DHB colleagues and related networks, and negotiating with their own staff to juggle rosters and individual commitments at short notice.

Failure to fill the rostered shifts result in shuffling doctors around the hospital to optimise patient safety and service continuity or having to prioritise one service over another.

There is consensus that these last-minute arrangements can result in ‘less than ideal’ medical staff working in the hospital.

The Network has, through discussions with hospital managers, identified consistency in the session fees both planned or unplanned across rural hospitals. This was detailed earlier in this report (table 4).

A national recruitment service has the potential to mitigate these issues and stabilise the cost of locum sessions through more coordinated and forward planned locum placements.

Key points:

- The direct costs of recruiting rural hospital locums are not identifiable, as in many organisations they are incorporated in administrative and managerial accounting codes.
- The direct cost of rural hospital locum doctors is not nationally identifiable as many accounting practices do not identify this as a separate item of expenditure from permanent staff.
- A nationally coordinated pool of rural hospital locum doctors, rostered over a 12-month period, across participating hospitals is likely to provide financial and logistical benefits to both the hospitals and the locum workforce.
- An urgent locum service, that is well resourced, would reduce the drain on rural hospital operational resources and contain the escalating costs of locum services.
- The Framework for rural hospitals rostering of locum doctors provides a platform from which RGPN NZLocums management have assessed the ability to leverage of their current service models to establish a nationally coordinated rural hospital locum doctor service.

5. Leveraging a Rural Hospital Locums Service Against NZLocums Existing Services

The NZ Rural General Practice Network has been providing medical recruitment services for nearly 20 years under its internationally recognised NZLocums brand. Through its contract with the Ministry of Health, the NZLocums teams are able to ensure that rural GPs and their families get an annual two-week break or have access to locum doctors to fill gaps in their service that are caused by rural health workforce shortages and the everyday realities of providing services rurally.

The expertise and reputation of NZLocums is recognised across both the health and recruitment sectors. Evidence of this was seen in 2019 when the team were awarded the SEEK annual recruitment award for medium sized agencies. In 2020 they were asked by the Ministry to respond quickly to the pressures Covid-19 placed on the rural general practice workforce through a one-off pandemic emergency roving locum contract known as PERL. This initiative won the best product/service or campaign award at the NZ Primary Healthcare Awards May 2021.

> "This service fills a very necessary gap as the stresses on rural clinicians is leading to a reduction in availability and access. Stress and burnout can be greater in the rural areas and so leave for the rural clinicians is crucial in order to improve equity. While funding is available, there is still a lot involved in finding a locum. The placement numbers are great."
>
> *Judge's comment, Primary Healthcare Awards, May 2021*

Each year over 130 placements are made from both an NZ based pool of rural GP locums[xiii], and a continuous international recruitment programme. A comprehensive marketing campaign that includes exhibiting at NZ and international health conferences and recruitment fairs, direct marketing to key stakeholders, and international forums and interviews with potential candidates, maintains a large pool of locum doctors who are available for placement across rural general practices.

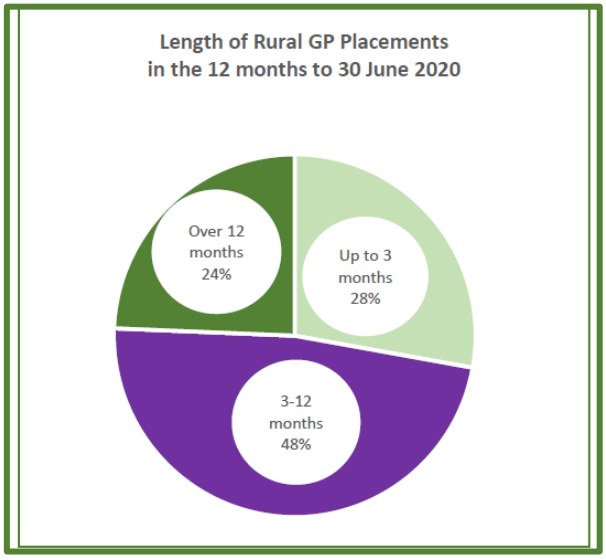

Fig 4 Length of NZLocums placements year to 30 June 2020

The infrastructure, relationships, and marketing approach that NZLocums has developed, and its commitment to maintaining high levels of expertise in its staff, provides a platform from which service capacity can be developed. The PERL contract demonstrates how this enabled the service to be developed and provided in a very short timeframe and by utilising existing systems and increased economies of scale, achieved a low per-placement cost of recruitment.

The short-term response toward a long-term goal

The Network works on the premise that while locum recruitment is the focus of its contract with the Ministry, the permanent placement of doctors is the ultimate goal. This is particularly relevant to assessing the return on investment into international recruitment as the Survey Report respondents said this was one of the main barriers to them recruiting internationally for medical staff.

This underpins NZLocums approach to screening and selecting international candidates as it is not only the needs of the candidate, but those of their family who will be coming to NZ with them, that are taken into consideration when matching them with a position in a rural general practice.

In the long term, the Network's advocacy position to Government is to increase the NZ trained rural health workforce by adopting a 'by rural, for rural, in rural' approach to educating and training NZs future rural health workforce. Rural hospitals are fundamental to this nationally dispersed approach to building our future rural health workforce but in the short and medium term, increasing the pool of doctors available for positions in both rural general practice and rural hospitals is critical to mitigating the impact of the rural health workforce crisis. A significant component of this is the continuous stream of IMGs recruited to come to NZ to work. However, due to the raft of academic qualifications that are likely to be presented by internationally trained hospital doctors, a rural hospital locum recruitment service is likely to need clinical oversight of candidate selection to ensure their qualifications and experience aligns with the MCNZ registration requirements, and the needs of the employing NZ rural hospital.

Understanding Rural Communities and the Rural Health Workforce

Recruitment of rural health professionals relies on the understanding that this is a uniquely different proposition to recruitment into urban services.

The implementation of the NZ Health Reforms is likely to see rural hospitals included in larger planning and commissioning processes which may have less connection to the realities of rural service provision. There has long been a concern that urban centric planning and funding of health services results in urban centric models of care, and consequently, the allocation of resources. This may reduce the focus on rural hospital issues, and in particular, their workforce challenges.

The NZ Health system could mitigate the risks of this occurring by building on the Network's reputation for being the central repository of rural health expertise, and its effective relationships across rural NZ to alleviate the rural hospital medical workforce issues. The Network maintains its relationships with rural NZ through:

- Its Governance Board membership that mirrors the rural health sector – 25% of its members work in rural hospitals.
- The annual National Rural Health Conference that is well attended by rural hospital doctors, nurses, and managers.
- Partnering with the RNZCGP to facilitate an annual Rural Research Day.
- Providing full resourcing for the Rural Hospital Network including facilitating the annual Rural Hospital Summit and preparing the resulting Summit paper.
- Providing full resourcing for the Rural Health Alliance Aotearoa NZ which connects Network staff to rural and agribusiness organisations. The Network also facilitates the RHAANZ annual RuralFest event and prepares the resulting Rural Health Road Map.
- Provides secretariat support for Rural Nurses NZ.
- Runs a year-round Rural Health Careers Promotion Programme that sees Network staff and partners regularly working with the tertiary Students of Rural Health Aotearoa (SORHA) in rural secondary schools to encourage pupils to consider a career in rural health.
- NZLocums Recruitment Relationship Managers visit rural general practices on a regular basis – this is critical to understanding their needs as our clients.
- Network staff regularly visit rural general practices and hospitals in the course of a year's activities.

Through this vast array of interactions and activities, the Network maintains a high level of understanding of the challenges of living and working in a rural community. We are certain that this is critical to successfully recruiting medical staff and has the potential to mitigate the impact that centralisation of hospital service planning and commissioning could have on our rural health workforce and ultimately, the health outcomes of rural NZ.

Medical Council NZ registration

The logistical challenges of an IMG moving to NZ, with their family, to work in rural NZ can be daunting at best. Over the last 20 years NZLocums has built relationships with key stakeholders to streamline these processes so that we are able to optimise the conversion rate of IMGs expressing an interest in working in NZ to this becoming their reality.

A critical component of this is an effective working relationship with the Medical Council NZ (MCNZ). It informs NZLocums international recruitment campaigns that are targeted at countries where there is a higher degree of compatibility with registration requirements.

NZLocums and MCNZ meet regularly to discuss practical arrangements including the orientation of IMGs to the NZ Health system, their supervision once working in the rural general practice, and collaboratively resolving issues as they arise.

The relationship between NZLocums and the MCNZ will increase the ability to develop an international recruitment campaign for rural hospital doctors. This would benefit both the candidates and the employing rural hospital through orientation and supervision arrangements aligned to the hospital's existing clinical governance arrangements.

Immigration Processes and Applications

NZLocums expertise in immigration processes is an excellent resource for international candidates as they work through their own immigration application. It streamlines the process so that candidates can move through it smoothly and are not 'put off' by the complex nature of this aspect of their move to NZ to work.

The Network also works closely with the Ministry of Immigration to address policy issues or complexities that have arisen through the Covid-19 border restrictions. In a Rural Hospital Locum doctor service, NZLocums would need to work with the Rural Hospitals, to:

- Have them accredited with Immigration NZ.
- Demonstrate that a medical vacancy has been genuinely advertised in NZ and that there are no NZ doctors available to do the job.

Orientation to the NZ Health System

Survey Report respondents said that rurally placed IMGs must be oriented to the NZ Health System, arrive on site with registration and compliance processes complete, and be familiar with locality focused systems.

The Network concurs with this view and since the early days of the NZLocums recruitment services has provided a three-day Orientation Programme for the IMGs once they have arrived in NZ.

The Orientation Programme is funded through the Ministry contract and is endorsed by the RNZCGP's CME programme to ensure it meets the needs of the medical profession and maintains high standards of quality. It includes sessions that ensure the IMG is logistically ready to start work in a rural general practice, has a high-level understanding of the NZ Health system and understands our commitment to the Treaty of Waitangi and Māori health outcomes.

A rural hospital focussed orientation programme will be important to the successful placement of IMGs. About half of the content of the existing orientation programme is relevant to rural hospital candidates, and some new content would need to be developed to ensure candidates are introduced to the DHB (or future equivalent) systems and the unique nature of working in a rural hospital environment.

Targeted international advertising and recruitment campaigns

So, while it is recognised that many of the NZLocums rural general practice clients acknowledge a preference that locum doctors are NZ trained, the Medical Council's 2019 workforce survey showed that over half (52.9%) of RHM doctors are IMGs.[xiv]

To that end, NZLocums has established a multi-pronged international advertising and recruitment campaign that targets countries whose doctors are well suited to working in rural NZ and are likely to result in a high level of locum applications. Through internet-based advertising, exhibiting at international medical conferences and recruitment fairs, and face to face meetings with doctors in their own country, NZLocums maintains a constant stream of IMGs into NZ for varying lengths of time.

This programme is easily extendable to multi-faceted marketing opportunities for rural hospital vacancies. It could leverage off the NZLocums current investment in its engagement with international conferences and recruitment activities.

NZLocums advises that on average, it takes 9 – 12 months from the first contact with an IMG interested in working in NZ, to their arrival here. This means, a national rural hospital recruitment service will require at least two years of operating until recruitment placement volumes can be identified.

Key points

- Critical success factors of a nationally provided rural hospital locum recruitment service include:
  - Effective relationships with rural hospitals and the communities in which they work.
  - Excellent relationships with MCNZ and Immigration NZ.
  - Comprehensive knowledge and experience in working with MCNZ and Immigration policy requirements.
  - NZ clinical / academic oversight of candidate selection.
  - A rural hospital three-day Orientation Programme for IMGs arriving in NZ.
  - A cost-effective international recruitment campaign.
  - A whanau approach to recruitment that meets short term needs but aims for long term outcomes.
  - Realistic goals for placing international candidates that reflect recruitment lead-in times.

6. The Development of a National Rural Hospital Locum Recruitment Service

Close consultation with rural hospitals to design a recruitment model that is effective, may require them to adapt the way they plan for locum cover on an annual cycle of leave, CME requirements and respond to long term gaps in their medical workforce.

A national rural hospital locum service has the opportunity to disrupt this and, over a two-three year period, create a nationwide, well-resourced and cost effective platform from which rural hospitals can meet urgent and planned medical locum requirements.

Levels of Locum Service Responses

The Framework for rural hospitals recruitment of locum doctors is reflected in the Network's advice that there are four levels of a nationally coordinated rural hospital locum service. These would require systems and service development over a period of two-three years:

Locum Response	Duration of Locum	Reason for Locum Service	Components of Service Delivery
Urgent	1-7 days	Arising from the unplanned absence of a doctor from the current roster	* Initial then ongoing relationship with rural hospitals as NZLocums clients * Online interactive platform that connects rural hospitals, the pool of NZ based locum doctors and NZLocums * Virtual emergency consultation support to nurse led services. * Expansion of NZLocums Recruitment Software to include Rural Hospitals, and medical candidates * Establishment of a NZ based pool of rural hospital medical locums * International rural hospital medicine marketing campaign * Streamlining MCNZ and INZ policies to meet registration, credentialling and visa requirements * Development of a Rural Hospital Orientation Programme
Planned	7 days – 6 months	Annual, study, CME or family leave	
Long term	6 months and over	Maternity leave, sabbatical, unfilled staff vacancy	
Permanent	Over 1 year		

Table 3 Levels of Locum Service

Three Year Programme to Establish the Service

Year	Deliverable
Year 1	* IT systems developed, and current systems expanded * Work with MCNZ to adapt internal recruitment policies and procedures so they meet requirements for registration, credentialling and ongoing supervision * NZLocums staff to familiarise and understand the Immigration requirements for rural hospital medical professionals * Secure medical/; academic oversight to candidate selection * International recruitment marketing campaign * Establish relationships with rural hospitals as clients * Establish a pool of NZ based rural hospital locum doctors as candidates * Begin placement of NZ based locum doctors * Review progress
Year 2	* Begin placing internationally recruited doctors into rural hospital locum role * Intensify the international marketing opportunities to rapidly increase the pool of candidates willing to work in NZ rural hospitals * Review progress and report on impact of the service to date
Year 3	* Service is fully operational, reporting on numbers of locum doctors placed in rural hospitals * Review efficacy of the service, and recommend future service deliverables

Table 4 High level programme of service development

Advantages and Disadvantages of a National Rural Hospital Locum Doctor Recruitment Service

Stakeholder	Anticipated Advantages	Possible Disadvantages
Rural Communities	* Service continuity * Reliable access to rural hospital services * Rural hospital sustainability	Regular rostering of locum doctors disrupts patient-doctor relationships
Hospital Staff Doctors	* Greater ability to plan for leave and time away * Less pressure to change shifts to fill urgent and planned gaps in rosters * Reduction in systemically driven burnout * Confidence that IMGs have been appropriately screened, registration compliant, and oriented to NZ health system * Increased clinical safety	Regular rostering of locum doctors disrupts workplace relationships
Locum Doctors	* Greater ability to plan locum shifts * Greater choice of hospitals * Confidence in locum colleagues skills and expertise	Reduced ability to set shift rates based on urgency of locum need
Rural Hospital	* Increased clinical safety * Greater ability to source locum doctors both NZ based and internationally recruited. * Confidence that internationally recruited doctors have been screened and meet MCNZ registration requirements * Reduced cost of locum doctor * Reduced cost of recruitment * Reduced staff time required to fill particularly urgent locum shifts	Greater need to plan for locum services on a nationally coordinated calendar
DHBs or Locality Based organisations	* Confidence that rural hospitals are staffed with appropriated qualified and experienced locum staff * Reduced costs of recruitment agency services * Reduced staff time required to recruit and urgent locum shifts	Greater awareness of the locum needs of rural hospitals in their region
Ministry of Health	* Greater efficiencies across the NZ Health budget of staffing rural hospitals * Greater confidence in the clinical expertise of the rural hospital locum workforce	Contracted recruitment services front-foots the costs that are currently absorbed by DHBs or NGO contracted hospital

Table 5 Advantages and Disadvantages of a national rural hospital recruitment service

Key points

- There are 4 levels of locum service response that would be required to deliver a national rural hospital locum doctor recruitment service:
  - Urgent 1-7 days
  - Planned 7 days – 6 months
  - Long term 6 – 12 months
  - Permanent Over 12 months
- NZLocums would require three years to establish a reliable and sustainable service that optimises technology, has a pool of NZ based and international locum doctors, has given rural hospitals time to adapt their current processes to move to a national recruitment service, and can credibly contract for future services on a volume basis.
- There are sector wide advantages both clinical and financial of a nationally coordinated rural hospital locum service
- The Rural Hospital Workforce Survey Report, 2020 has made a significant contribution to both the Rural Hospital Network and RGPNs preparation of this report.

Acronyms and Abbreviations used in this report

Acronym/ Abbreviation	Detail
DRHM	Division of Rural Hospital Medicine
RHMS	Rural Hospital Medicine Specialist
RHMR	Rural Hospital Medicine Registrar
GP	General Practitioner
FACEM	Fellow Australasian College of Emergency Medicine
Network	NZ Rural General Practice Network
RHN	NZ Rural Hospital Network
ED	Emergency Department
IMG	International Medical Graduate
MCNZ	Medical Council of NZ
RNZCGP	Royal NZ College of GPs

End Notes

[i] Rural Hospital Workforce Survey Report, 2020 Report Table 1
[ii] Rural Hospital Workforce Survey Report, 2020 Report Table 2
[iii] This estimate is based on the Rural Hospital Workforce Survey Report, 2020 Survey and additional information provided directly to RGPN from hospitals that did not respond to the survey
[iv] The NZ Rural Hospital Doctors Workforce Survey 2015, Ross Lawrenson, James Reid, Garry Nixon, Andrew Laurenson

[vi] Rural Hospital Workforce Survey Report, 2020 Figure 7. Presence of a clinical director
[vii] Rural Hospital Workforce Survey Report, 2020 Table 5: Characteristics of doctors participating in the Rural Hospital Doctor Survey
[i] ASMS Research Brief: Rural Health at a crossroads Issue 28, 2021
[viii] Rural Hospital Workforce Survey Report, 2020 Report Table 5: Characteristics of doctors participating in the Rural Hospital Doctor Survey
[ix] Health Dialogue – Burnout, ASMS 2021
[x] 2020 Workforce Survey
[xi]"Are locums cost effective? A review Royal Australasian College of Medical Administrators Quarter 2 2019
[xii] Rural Hospital Workforce Survey Report, 2020 Report Fig 2 Availability of medical staff and locums per hospital
[xiii] Source: NZLocums quarterly reports to MOH on contracted service delivery
[xiv] Medical Council of New Zealand (MCNZ). The New Zealand Medical Workforce in 2019. Wellington: MCNZ. 2020.

Appendix 1

As a separate document:
"Rural Hospital Workforce Survey Report, 2020" Professor Ross Lawrenson, Bernadette Doube, and Tania Blackmore