HealthManagement
Promoting Management and Leadership

Volume 13, Issue 4/2011 - Personnel Management

The Financial Cost of Locum Doctors

Definition:

Locum: A person who stands in temporarily for someone else of the same profession, especially a cleric or doctor (OED).

Introduction

The Mid-Western Regional Hospital (MWRH) in Dooradoyle, Limerick, Ireland has an Emergency Department (ED) staff complement of nine Senior House Officers (SHO) and six Registrars required for 24-hour emergency medicine cover for each sixmonth interval; in addition five consultants are attached to the department in clinical and administrative roles. In 2010, there were a total of 60,001 presentations to the ED with 16,325 admissions. Gaps in the normal duty roster have been increasing and locum cover has been used in order to provide adequate service to the community.

The cost to hospitals for employment of locum doctors has increased two-fold in the last decade in Ireland with locums providing five percent of the total staffing. Accurate statistics nationally are difficult to obtain but concerns about lack of physicians, up to 400 Non-Consultant Hospital Doctors (NCHD) short of required numbers were expected in July 2011, are worrisome. A multiplicity of issues have ended in congruence; lack of junior physicians to staff the nation's hospitals, in particular Emergency Departments.

The issues are multiple; attempts at European Working Time Act (EWTA) compliance without an increase in staff coupled with migration of qualified doctors to foreign shores are two of the major causes. Additionally, with growing numbers of women entering the workforce, maternity leave is an increasingly important aspect that is often not considered in workforce planning. The cost to hospitals for locums is known as a line item in hospital budgets, but most investigations of this cost do not take into account the actions of the current hiring freeze on NCHDs and changes in work and payment practices. The fiscal benefit to locums has not been previously elucidated in the literature as a causative factor in the decision to work as a locum.

Methods

A retrospective audit was completed on four SHOs working in the Emergency Department, MWRH. Three were full-time NCHDs and one was a full time locum. Each worked eight hour shifts for three weeks, Monday to Friday. One weekend was worked by each physician in the study period however this was excluded as shift timings and staff complement changes on the weekend. All other SHOs were excluded as they did not work a complete three week period during the month of November. An electronic log of all patients seen including the variables of sex, age, and triage category was generated from the Information Technology Department, MWRH. The resultant Excel spreadsheet was used to analyse the data and generate the average triage category seen by both the locum and staff SHOs and the number of patients seen, on average, per hour. The cost per hour to the hospital was obtained from the Human Resources department for both locum and staff SHOs.

Results

Averages

During the 15 day study period the NCHDs saw a minimum of 117 patients to a maximum 178 patients. The MWRH uses the Manchester Triage scoring system for patients.

The average patients seen per hour for staff SHO's was 1.08 and for the locum SHO it was 1.48. The average across the four SHOs in terms of patients seen per hour was 1.18.

Monetary Calculations

The cost for a staff SHO to the hospital is 42.75 Euro/hour. This rate is based on the maximum point of the pay scale as of 1/1/2010 and includes all extras including overtime, weekend pay, and employers PRSI of 10.75%. Locum rates currently for the MWRH are 44 Euro/hour from 9am-5pm, 5pm-9am 52.8 Euro/hour,and a flat Sunday rate of 57.2Euro/hour. With the average of 1.18 patients/hour the cost to the hospital for a staff SHO was 36.23 Euro/patient and for the Locum SHO it is 37.28 - 48.47 Euro/patient.

Locum Remuneration

A staff SHO at the base hourly rate receives 19.0858 Euro/hour, from which Levy, PRD, income tax, PRSI contribution, Pension 165, and Pension 325 are deducted.

Discussion

The NCHDs treated from 117 to 178 patients during the study period. This difference can be partially accounted for by the different average of triage category seen; a higher triage number indicates less acute patients and a likely faster time from presentation to discharge or admission. The data supports this in that the highest number of patients seen, 178, resulted in an average triage score of 3.25 versus a score of 2.87 and

117 patients seen.

The average number of patients seen ranged from 1.08 per hour for the staff SHOs and for the locum SHO it was 1.48. This discrepancy is quite large and could potentially not be indicative of actual averages. More locum statistics would be necessary to add strength to the study in addition to more statistics from throughout the year and more staff SHOs. With locum doctors working in likely unfamiliar environments and with new coding systems it could be suspected that they would actually see fewer patients/hour than staff SHOs; more research is needed into this area of providing healthcare.

A major difference arises when calculating the monetary amount that reaches the physicians' bank account. With tax incentives and incorporation a locum doctor can receive the full amount of the hospital payout and write a large portion of it off pre-taxation. Expenses relating to educational, travel, and living costs, which can be substantial, can be written off before declaring the remainder as income. The locum SHO has the potential to earn 57.2 Euro/hr compared to less than 19 Euro/hr for a staff SHO depending on the day, time, and tax deductions.

The cost to hospitals for locum SHO cover, in budget calculations is worrisome. However, the relationship between cost of locum cover and the decrease in the amount that is being paid to staff SHOs needs to be taken into account when discussing the cost of locum physicians. The question needs to be asked: If there was no hiring freeze and EWTA implementation how many more doctors would have been hired, and would this eliminate the need for locum cover to the extent that it now exists? As this study shows, the bottom line to hospital accounts should be relatively neutral as the cost/patient seen by a locum SHOs and staff SHOs is roughly equivalent.

Other aspects of arranging locum cover include the increased administrative work for organising locums and this cost has not been previously calculated as have any payment relations between hospitals, the HSE, and the locum agencies for their work. There is also an assumption that full time NCHDs are more likely to undergo full vetting and English language competency assessment in comparison to locum SHOs which is an important prospect in terms of quality assurance. Whether shortcuts have occurred because of the crisis has not been examined.

What is clear is that the potential earnings that NCHDs can make is substantially increased by working as a locum. With the current economic doldrums and lack of training opportunities in the system coupled with increasing levels of graduating medical student debt, locuming could continue to attract more doctors looking for short-term exits from the current system of training and remuneration before re-entering the training system here or abroad.

Conflicts

Paul Dhillon was a locum doctor during the audit period. The concept of the audit and study was conceived after the month of November. Data from Andrew Murphy was used in the audit however he was blinded to it.

Acknowledgement

Thank you to Jacki Tobin, IT Department, MWRH for data generation and technical support.

Figure 1. Patient data for the 15 day study period

Figure 2. SHO remuneration

Published on : Mon, 12 Dec 2011