Workforce Survey July 2023

Kotahitanga me Manaakitanga

Finding strength in our unity, supporting our community

17 July 2023

Introduction

On the 1st of July 2022, New Zealand's new health system was launched. The centralised Te Whatu Ora and Te Aka Whai Ora (Māori Health Authority) were created in place of the multiple entities which had previously existed.

The intervening year has been characterised by a difficult transition period for the medical workforce and the patients they serve. Strains on the health system have featured prominently in news cycles, including lengthy wait times for both emergency and elective procedures and staff shortages across the board. Measures have been announced to address these, but healthcare practitioners report that little has changed on the ground as yet. At the time of 2022's NZ Women in Medicine work survey, almost 94% of respondents felt that there was a 'crisis' in the health service. What has changed?

This year's survey presents a snapshot of the current state of the medical workforce. Results are spread across primary care (GPs- 54%), secondary care doctors (41%) and 'other' (5%), which include doctors not currently working clinically, for example in research. Findings suggest that the majority of respondents feel that they have not been offered opportunities to input into the reforms which affect them : that their voices have not been heard. This raises concerns. An unengaged workforce, struggling with burnout and low resourcing, may find it difficult to embrace the systemic change required to 'turn the ship around'.

Achieving Pae Ora for New Zealand is possible only with a well-supported health workforce whose experience and autonomy is valued and respected. We urge health leaders to continue to engage, listen to and work constructively with its medical, nursing & allied staff: we are all in this waka together.

Dr Orna McGinn

Chair, NZ Women in Medicine

Dr Justine Lancaster

Deputy Chair, NZ Women in Medicine

Survey questions

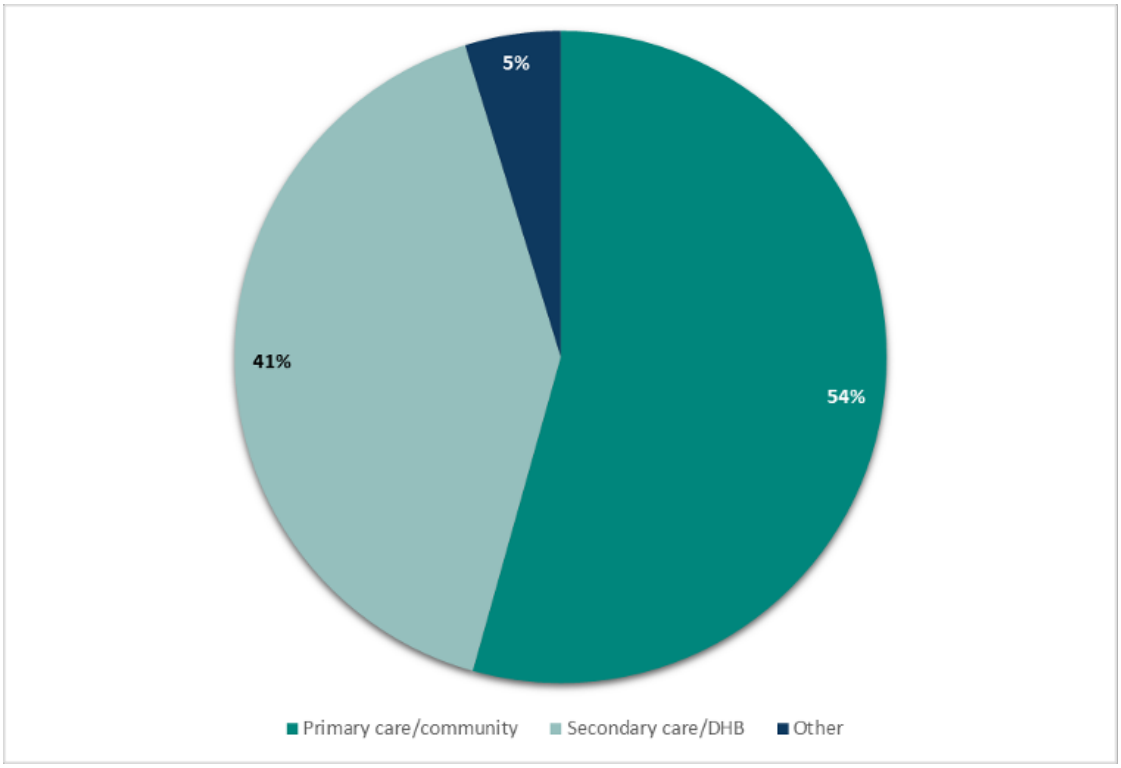
1. Where do you predominantly work?
2. Compared with 1 year ago, are your working conditions: (much better/somewhat better/about the same/somewhat worse/much worse).
3. Do you think it likely that conditions in your workplace will improve over the next year?
4. To what extent do you agree with the following statement: I have been given opportunities to give feedback on the health reform process as relating to my area of work.
5. What is the one measure which would have the greatest impact on your ability to care for your patients effectively, if implemented immediately?

Results

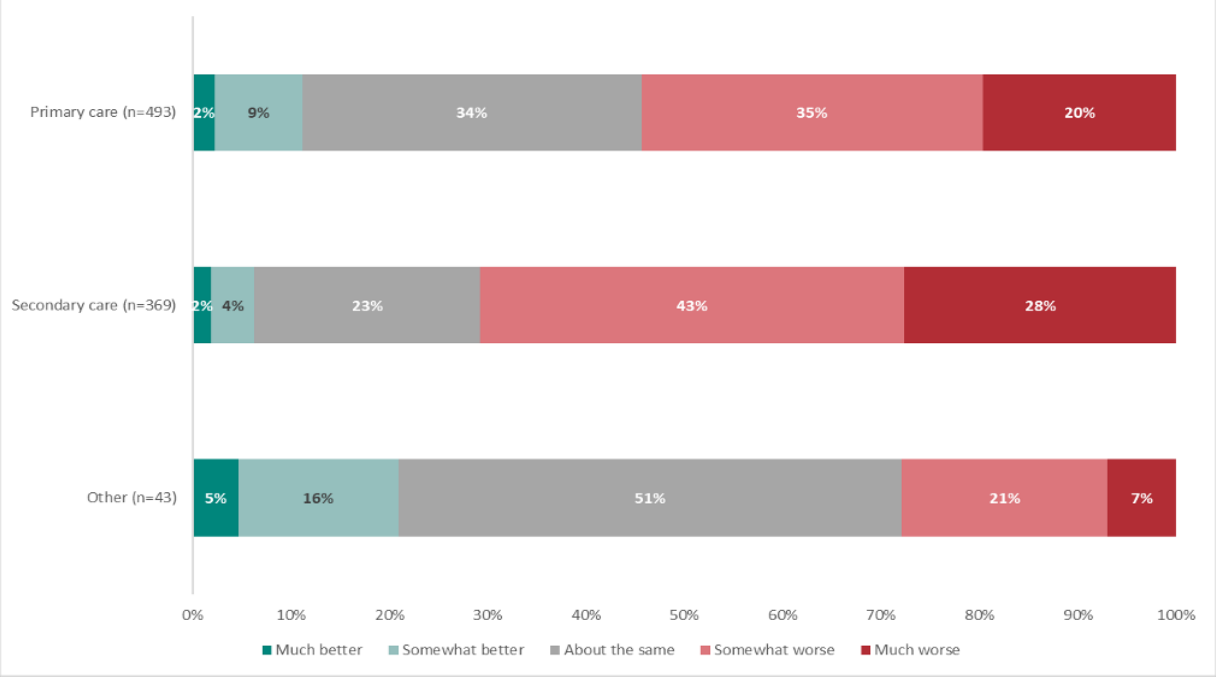
A short mixed- methods survey with 5 questions was shared with NZWIM members in May 2023. Three were multiple choice questions; the first was a question about respondents' place of work (predominantly primary care, predominantly secondary care, or 'other'), where one answer was possible. Questions 2,3 and 4 were single answer multiple choice questions, with a 5-point Likert scale. Question 5 was an open question allowing for text responses. The answers to this question were first divided into respondents' primary place of work, and then collated and grouped according to theme.

Of the 936 respondents, 54% worked in primary care, 41% in secondary care, and 5% in other workplaces such as rural hospital , community laboratory, University or other research facility, central government, Te Whatu Ora non-clinical roles, or in public health.

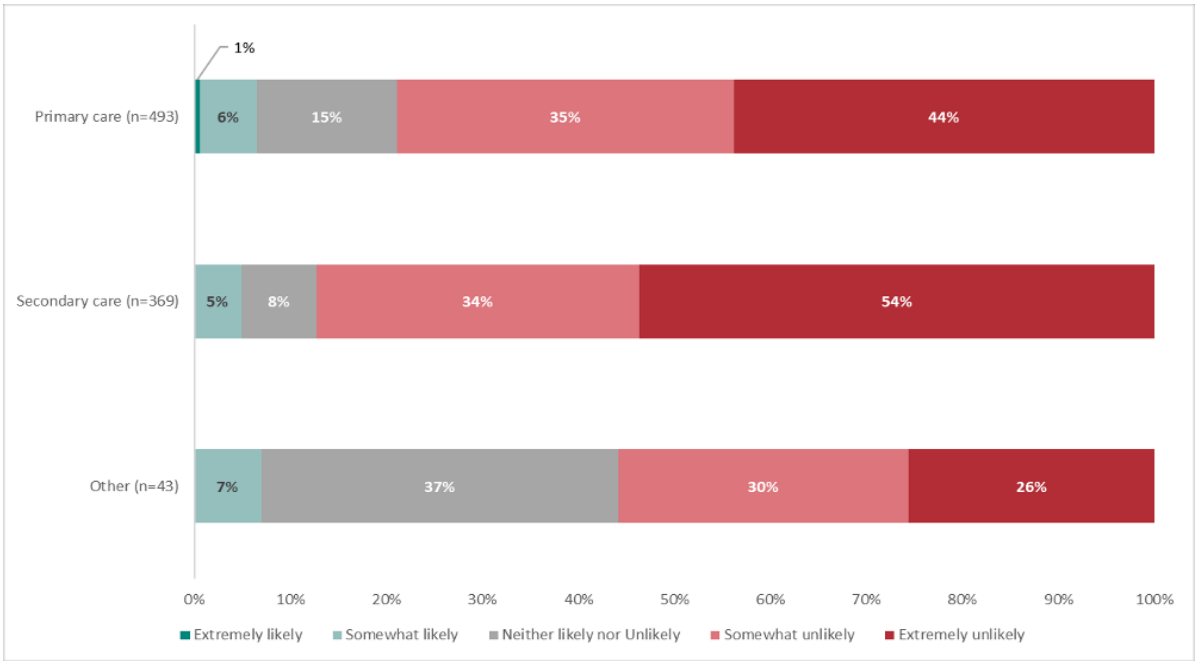
Q1. Respondent demographics by sector (n=936)



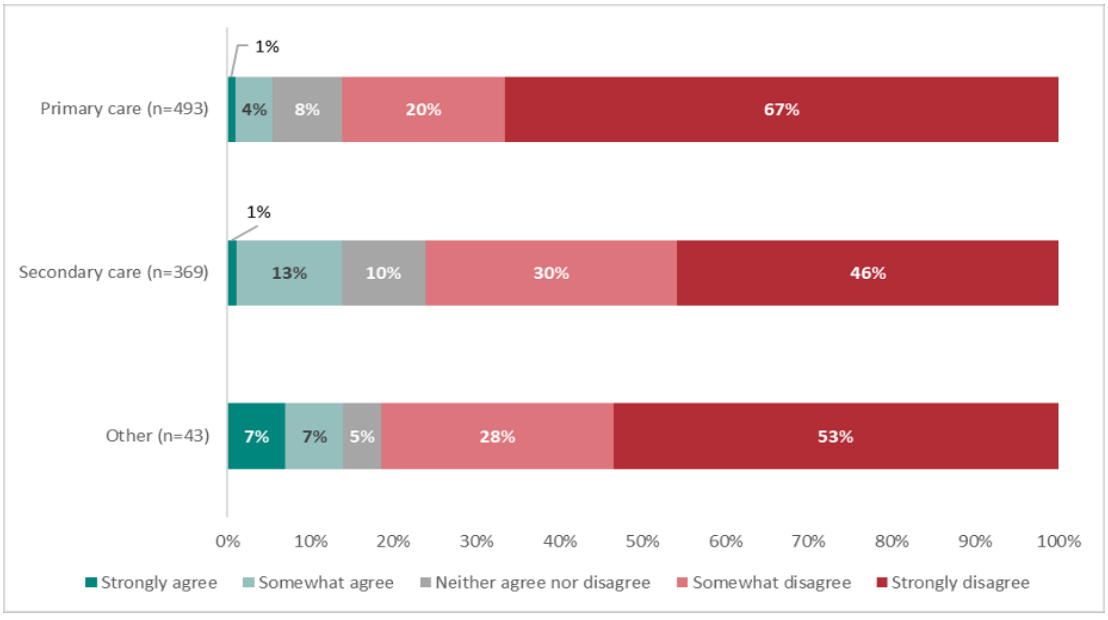
Q2. Compared with 1 year ago, are your working conditions:



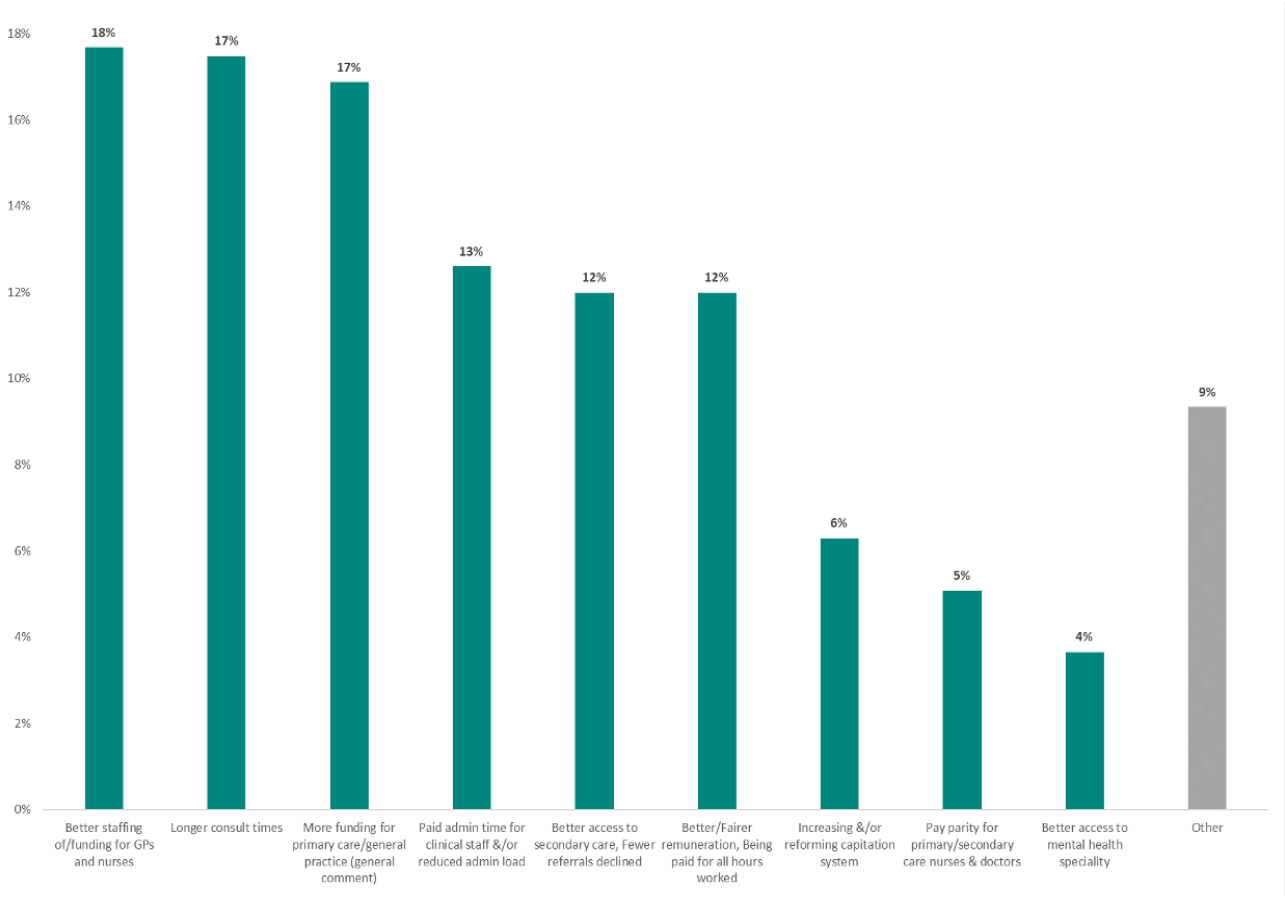
Q3. Do you think it likely that conditions in your workplace will improve over the next year?



Q4. To what extent do you agree with the following statement: I have been given opportunities to give feedback on the health reform process as relating to my area of work.



Q5. What is the one measure which would have the greatest impact on your ability to care for your patients effectively, if implemented immediately? (PRIMARY CARE : n=492)



Thematic analysis of qualitative data : Primary care

492 primary care/community doctors chose to make a comment in response to the question, “What is the one measure which would have the greatest impact on your ability to care for your patients effectively, if implemented immediately?”. The open text data was analysed using thematic analysis.

Funding and resourcing (66%)

The most common themes in the open text data centred on the need for more staffing, funding and resourcing. In total, two thirds of respondents mentioned these issues. The comments were broken down further into specific areas highlighted as requiring funding.

18% of respondents commented that increased funding was needed to hire more nurses and/or doctors.

17% made a general comment around funding, and 6% made a comment that increased funding was necessary through either increased capitation or a reform of the capitation funding system.

13% commented that their unpaid administrative load was unsustainable and unfair. 12% commented that that currently they were not being paid for all hours worked.

For example:

> *Increased funding and resourcing to primary care. Funding has not kept up with inflation, nor increasing patient complexity, along with the hospital pushing everything back onto us. So we are doing more work for less pay. Please do something urgently because I'm on the verge of quitting like many of my colleagues. I love being a GP and don't want to quit but cannot go working under the current model.*

> *Increased funding to pay nurses. We can't fill positions because there are so many jobs for nurses at the hospital that pay better. It's horrendous having days where it's down to just 1 GP (me) and no nurse sometimes. Even worse when ED is overwhelmed and asking patients to see me instead!*

> *Fund GPs to 10-14% of the health budget to be in line with other similar countries (UK, Australia, Canada). Every study says better health outcomes with properly resourced primary care - why is the government intent on killing off GPs/GP profession? They're killing patients along with it.*

> *ADEQUATE FUNDING! We are now cutting services, our dwindling nurses are struggling to recall and perform immunisations, our GPs are leaving for Australia, higher paid regions within NZ, or* [hospital] *roles. Either fund us properly or give us SMO salaries and underwrite or buy the practices; if this does not occur General Practice and therefore Primary Care will collapse in 3-5 years, sooner in high needs regions like ours where we have lost one third of our GPs in the last 18 months. My wife…and I are now going to Australia in July to explore work opportunities, we made this decision when this Government announced a 5% increase in capitation and an even lesser amount for co-payments despite inflation and the 2022 Sapere report.*

> *Appropriate long term general practice funding! This would enable us as GP owners to properly fund the work our staff do and to increase the size of our team at all levels to effectively complete the work. This*

would provide better and more sustainable working conditions, reduce burnout, allow for more timely access to care, and cater better to the large proportion of patients in our community who can't enrol with a GP. If we carry on the way we are going, there'll be no one left in primary care.

Increase capitation to above CPI [consumer price index] *so can pay and hire more/ better/ancillary staff, offer more hours, improve equipment, undertake training*

Changing capitation formula and back paying the $$ we get from govt to be annually adjusted for inflation/cost of living as well as fair adjustments going forwards (including pay equity for our nurses)

13% commented that their unpaid administrative load was unsustainable and unfair.

Being paid for the hours of unpaid paperwork/phone calls etc generated by a full patient load. In order to remain financially viable we need to see a certain number of patients, but the work we do outside seeing patients is a lot. Who pays for that?

Fund general practice adequately so GPs are remunerated for all clinical work not just patient facing 15-minute appointments.

There need to be more IT solutions to reduce the paperwork burden, It's like working in treacle constantly and exhausting. Capitation needs to reflect the huge hours we're spending processing paperwork for all and sundry. It would be nice to be paid for this work.

Longer consult time needed

Another common theme was that a consult time of longer than 15 minutes was necessary given patients' complex needs, with 17% of respondents choosing to make a comment about this. For example:

Fund GP for 30 min appointments rather than 15 mins. People are so complex with so many issues they want addressed that 15 mins is IMPOSSIBLE.

Time. 15 min model is killing good care. The more secondary care creates barriers and turfs and keeps complex patients in primary care, the more critical it is that there is time to manage these patients (and time to retain skills and learn).

16% seek better access to secondary care, particularly mental health specialist services.

12% of respondents chose to make a comment that they wanted to see better access to secondary care, stating that often their referral requests were declined and/or patients were referred back to them.

There is evidence of a growing weight of unmet need, with GPs having patients who meet clinical access criteria but are unable to access secondary care due to capacity and resource constraints. For example:

> *More access to tests/specialists in secondary care. Many of my referrals to secondary care are declined. It is also very difficult to get publicly funded imaging.*
>
> *Adequate and timely access to secondary care so that less patients get dumped back onto GPs*
>
> *Secondary care being able to accept more of my referrals. It is very hard being told my referral has been declined for capacity issues when there is nothing more I can do for the patient.*
>
> *More funded options for mental health support - including ADHD / ASD assessments, more ACC counselling and more counselling/ talking therapy for trauma, complex/ severe mental health issues that do not meet criteria for secondary services.*
>
> *Increased access to mental health support, meaning with actual people, not apps*
>
> *Ability to access mental health services for my patients especially young people and adolescents*

Pay parity

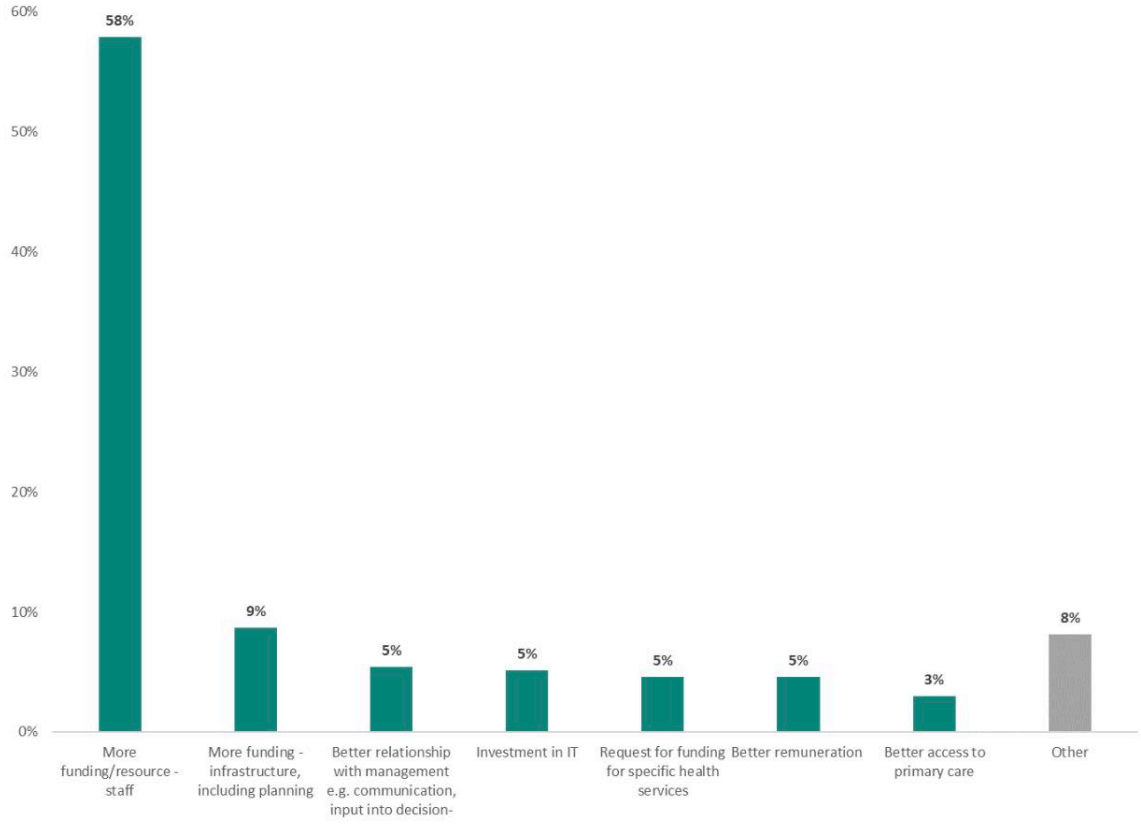
5% of respondents commented that pay parity between primary practice and hospital nurses, and between GPs and hospital doctors, was essential in order for GP practices to be able to recruit and retain staff.

> *Pay parity for primary care nurses. 2 out of 4 nurse colleagues have left/leaving soon for secondary care in the last 6 months.*
>
> *Pay parity for primary and secondary care*
>
> *Nurse pay parity, so we can retain our nurses*
>
> *Training more GPs which means making the job more attractive to Med Students which requires reducing the pay gap between GP and hospital specialists.*

Adequate funding for staff i.e. pay and conditions parity for all working in primary care when compared to Te Whatu Ora, and paying people for every hour they work. This would improve the workforce shortage overnight even before staff are recruited from overseas and new workforce trained.

Better funding for GPs - pay us as the specialists we are - pay/condition parity with the ASMS MECA. I was a full time GP but I've decreased my GP FTE and taken up some time at a hospital to be paid better and have better conditions. Effectively you've lost half a GP as I work elsewhere in a less important job for more pay/better conditions. The work I do as a GP is far more valuable to my community. I don't know why it's paid so badly by comparison. If GPs had pay parity, I'd move back full time into GP where I can do far more with primary care/prevention, decreasing secondary care costs.

Q5. What is the one measure which would have the greatest impact on your ability to care for your patients effectively, if implemented immediately? (SECONDARY CARE n= 370)



Thematic analysis of qualitative data : Secondary care

370 secondary care/hospital based doctors chose to make a comment in response to the question, “What is the one measure which would have the greatest impact on your ability to care for your patients effectively, if implemented immediately?”. The open text data was analysed using thematic analysis.

Increased funding to adequately resource staffing levels

The most common theme in the open text data (58% respondents) was the need for more funding and resourcing for staff across all areas of secondary care, including in nursing, allied health, and administrative functions.

For example:

> *Increase in junior staff support - House surgeons and non-training registrars. Currently jobs are so miserable for them that we cannot recruit nor retain staff let alone staff who may wish to pursue a career in our surgical specialty.*
>
> *More staffing (we currently have an unfilled SMO vacancy, no leave cover for when registrar or house officer is away, no leave cover for chemotherapy nurse specialist and thrombosis nurse specialist or when our service coordinator is away). Everyone just has to cover for these absences and have done so since pre covid. We are all exhausted and this is impacting on patient care. Mostly in terms of delayed appointments but also in mistakes and near misses being made.*
>
> *More nursing staff and more medical staff. Which means better resourcing. No one can practice how they want to and everyone is burnt out. The only reason my conditions are somewhat better is because we spent 14 months with 4 of us doing the job of 7 people and we now have more staff. But the 4 of us are so tired we can hardly keep going and every week we (SMO) are asked to cover shortfalls in the registrar roster while every week nurses are being farewelled as they move to Australia. We can’t keep going like this. We are at a critical tipping point.*
>
> *Adequate nursing and midwifery staff...lack of support from other health professionals makes doctors work much harder, less supported and the situation for patients less safe.*
>
> *Fully staffed in all areas. Not the bare minimum but with sufficient to be able to respond to periods of increased need, provide leave, education, teaching, non-clinical time.*
>
> *Appropriately service sized FTE* [full time equivalent] *of support staff (schedulers, administration assistants). I’ve become a highly paid minute taker/equipment technician/orderer of consumables & stationery who occasionally sees patients.*

Increased administrative staff. We could see more patients but [we have]*not got the admin FTE to actually organise clinics or theatre at short notice.*

Right now the hospitals are understaffed across the board. We are absolutely stretched to capacity. We are constantly doing more than a usual, reasonable workload. We're all more tired than before, and it's also increasingly difficult to obtain leave because there's minimal cover. We feel undervalued, as no matter how much we do we're still being asked to do more. This is all leading to staff attrition, and people eventually leaving the sector – to go overseas where there is better pay or better opportunities, or going to work for Pharma companied that can provide better incentives and more favourable work hours....it is really understandable why people leave when they are overworked, underpaid and feel unappreciated.

More funding for infrastructure, including IT systems

9% of respondents made a comment relating to the need for more funding for infrastructure such as buildings and theatres, and an additional 5% commented on the need for better operational systems and IT.

For example:

Change public hospital booking systems. High DNA rates are partly our fault due to poor communication. Such a waste of resources!

Housing for staff. I am in Hawkes Bay and it is really hard to recruit & retain nursing and other healthcare staff due to the housing shortage here.

Increased bed capacity at my rural hospital

Funding for extra buildings, equipment, nursing etc. we have the doctor staffing to do extra clinics and theatres etc. but no room for more clinics, and no nurses to support them.

A fully integrated and interactive Electronic Medical Record

Linked up IT system and one which is fit for purpose (i.e. fast, streamlined and works the same in all locations and between primary care, secondary care and allied health)

Proper functional IT system - the delays & slow dysfunctional systems are soul destroying. There is no backup when the system fails & which is quite often - this puts patients at incredible risk. Print servers go down & we cannot print for hours - online prescribing goes down & patients cannot get their medications. I have worked in the financial sector as a consultant IT engineer & this DOES NOT happen there - they invest millions in their IT systems.

Positive culture change

5% of respondents made a comment seeking improvements in relationships with management or leaders.

For example:

> *Less interference from exec/management level, leaving us to make decisions about our own services. Better communication would also help.*
>
> *I would probably appreciate better, honest communication with the management. It has been fraught with lies and dishonesty for many years, and communication to improve patient care has been a one way street*
>
> *For the department to be led and managed by clinicians and not by managers*
>
> *The inability of our ELT* [Executive Leadership team] *to make any decisions without Te Whatu Ora hierarchy signing off is ridiculous. It is freezing hire and halting progress. Just a disaster, the whole system.*
>
> *Professional support for intra-departmental conflict.*
>
> *Listen to clinicians. Get rid of the layers of managers that are not clinical in TWO who block progress and innovation. Who is leading this reform? It is absolutely not clear.*

More funding for specific health services

5% of respondents made a comment relating to the need for more funding for their specific specialist areas.

For example:

> *Access to radiology during OP* [outpatient] *clinics*
>
> *Endorsement by TWO that multidisciplinary persistent pain services are a vital service required in each region to allow for ongoing pain management to address the current dire lack of access for New Zealanders - and permission for regional hospitals to staff appropriately with physicians, physios, psychologist, OT* [Occupational Therapy]*, nurses to enable concurrent care. I am most frustrated by hospital management always saying they can't make any decisions until TWO does- we'll be waiting forever.*
>
> *More funding for secondary mental health services. Also, there is no point TWO asking for and getting feedback if change doesn't happen.*

Free (truly free - not paying for speculums or GP visits) cervical screening + free self-swabbing when primary HPV screening is implemented (which is long overdue)

Better remuneration

5% of respondents would like to see better remuneration both for them and for other health professionals.

For example:

The poor staffing levels are absolutely demoralising. It is not uncommon for us to be running at 40% staffing levels. This includes nursing and Allied Health and I now HATE going to work and am actively looking to leave. I no longer believe that the health system can provide good quality safe healthcare. Everyone needs a pay rise and that is the SINGLE biggest thing you can do NOW to make the workforce feel better, retain staff and encourage good quality new people to train, retrain or come back to the broken system. Improved staffing [will result from] *better pay for everyone in healthcare from the cleaners and admin staff to the nurses, midwives, RMOs and SMOs.*

Stopping my nurses leaving (paying them well)

Increase pay and improve conditions to make the job more attractive (flexible working options, flexible use of CME [Continuous Medical Education] *money etc) so we may be able to retain more of the workforce.*

Better access to primary care

3% of respondents made a comment relating to primary care.

For example:

Adequate staffing of primary/community care (particularly nurses). I work in palliative care and the lack of community district nurses and community palliative care resource impacts on my patients and my decision *making every day. Delays discharge, leads to less than ideal patient care and increases my work load trying to problem solve.*

Better primary care funding to help prevent tertiary presentation in late phase of disease.

More community staff to care for patients on discharge, particularly at end of life but also those needing quickly reactive services, e.g. district nursing, care agencies and hospice.

Conclusion

The results of this survey allow some insight into the state of the health service one year post – reform, from the point of a large cohort of doctors working within it. There is a sense that the workforce is becoming disillusioned, and increasingly lacks faith in the ability of the reforms to deliver change. The majority of both primary and secondary care doctors surveyed (55% and 71%) rate their working conditions as either worse or much worse since the establishment of Te Whatu Ora in July 2022. Only 6% of primary care and 5% of secondary care doctors feel that improvement in their working conditions is extremely likely or likely within the next year.

Just 5% of primary care doctors and 14% of secondary care doctors felt that they had been able to give feedback on the transition process. This reflects widespread disappointment in the level of engagement of health leaders with those working clinically within the health sector. Clinicians can attest to the fact that co-design of services with patients leads to better health outcomes: it is discouraging that this co-design process has, in many cases, not extended to incorporating the lived experience of health staff in the restructure of the system in which they work.

When asked which single measure would make the biggest difference to their ability to care for patients, adequate funding and an overhaul of an outdated consultation model were the main concerns for primary care. Pay disparity between hospital and community-based nurses was cited repeatedly as causing difficulties for practices wishing to attract and retain nursing staff. In secondary care, lack of staffing across the board was the overwhelming issue. However, problems were reported at every level of the system – with poor infrastructure, inadequate IT support and the current crisis in primary care impacting on the ability of hospital doctors to work effectively. These findings suggest that the fragile health ecosystem is in danger of collapse, with pressure on overstretched primary care (in some areas, over 50% of GP practices are now closed to new patients)[1] leading to a downstream effect on secondary care services which are also under strain. It is clear that a robust New Zealand Primary Care Strategy is required, and the question as to why this was not seen as a priority in the new system must be asked.

Urgent action is now required to raise the morale of the workforce. Measures to address retention of current staff must be immediately prioritised by Te Whatu Ora, the Ministry of Health, the New Zealand Medical Council and the Council of Medical Colleges. A year into the new system, most frontline clinicians, and particularly those in primary care and the funded system have still not had an opportunity to contribute towards the development of the NZ Health Charter. We suggest that development of the Charter should be inclusive of the whole health system, and when released its contents should be communicated clearly to all in order to build trust.

These actions would represent a real commitment to achieving Pae Ora, which can only be achieved by ensuring that ***'health and care workers are valued, supported and well trained, supported by shared values, better long term planning, and collaboration between heath organisations to best serve our whānau and communities.'*** [2]

[1] GPNZ Closed Books Stocktake, July 2022

[2] The Health Charter – Te Mauri o Rongo. Appendix One : context

18 July 2023

Signatories to the 2023 NZWIM Workforce Survey

Dr Anna Bashford Medical Oncologist

Dr Susan Brooks Radiation Oncologist

Dr Suzanne Poole Respiratory Specialist

Dr Emma McMenamin Palliative Care SMO

Dr Genevieve Ostring Paediatric Rheumatologist

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Dr Renee Liang FRACP MNZM

Dr Victoria Francis Radiologist

Dr Angela Wong GP

Dr Rachael McEwing Obstetric Radiologist

Dr Vicki Robertson Gynaecologist

Dr Miriam Martín GP UC

Dr Hannah Walker GP

Dr Renuka Bhat

Dr Katy Roff GP

Dr Samantha Newman GP

Dr Kay Hall FACEM

Dr Kate Neas National Clinical Director Genetic Health Service

Dr Elizabeth Loudon

Dr Jodie Paterson GP

Dr R Holland House Officer

Dr Amy Tseng Anaesthetist

Dr Laura McAulay

Dr Melanie Garrett GP partner

Dr Mark Taylor GP owner

Dr Rachael Niederer Ophthalmology SMO

Dr Anna Hulme GPEP registrar

Dr Leigh Harvey Radiologist

Dr Rathi Rajasekaran Clinical Lead Urgent Care

Dr Caroline Maxwell GP Registrar

Dr Tim Weight Specialist GP & GPEP 1 teacher

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Dr Helen Davies GP Liason

Dr Thaya Ashman GP

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Dr Isobel Ferguson SHO

Dr Rachel Beard Developmental Paediatrician

Dr Eve Teo GP

Dr Lucy Stone Anaesthetist

Dr Sarah Holmes GPEP 3 registrar

Dr Noriko Noda GP

Dr Shona Roberts GP

Dr Danielle Gerrard GP & Community lead transforming diagnostic imaging TDI Northern Region Radiology

Dr Emily Marfell GP

Dr ML GP Blenheim

Dr Julia Eddington GP

Dr Margriet Dijkstra Rural Specialist GP

Dr Sarah Callaghan GP

Dr Mariam Contractor GP

Dr Nicholas Leydon GP

Dr Victoria Taylor GP

Dr Margaret Goodey GP Owner

Dr Lois Eva Gynaecological Oncologist

Dr Lydia Sudima GP

Dr Jill Devlin Obstetrics &Gynaecology SMO

Dr Anna Van de Merwe Obstetrics &Gynaecology SMP

Dr Rebecca Rowe GP

Dr Laura Davidson Cardiologist/ General Physician

Dr Euna Sahng General Physician/ Infectious Diseases Fellow

Dr Gina Kaye GP

Dr Katie Fourie GP IBCLC & Breast Physician

Dr Magdalena Biggar Breast ,Endocrine & General Surgeon

Dr Sandra Spilg GP

Dr Mary McWatters FRNZCGP

Dr Aimee Norman GP

Dr Yvonne Murray FRCPC FANZCA FFPMANZCA Taranaki Head Of Department of pain service that is collapsing without support or staff

Dr Emma Ellis MFM Subspecialist Counties & Auckland

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Dr Sarah Holmes

Dr Angela Lawson GP

Dr Whitney Davis GP/ IBCLC

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Dr Hannah Copeland GP

Dr Karen Napier GP

Dr Kathryn Chrystal Medical Oncologist Auckland City Hospital

Dr Luarell Tutone GPEP 3

Dr Wendy McRae Respiratory Physician Middlemore

Dr Michelle Bailey Gynaecologist & fertility subspecialist

Dr Carol Chan Consultant Paediatrician

Dr Suzanne Beuker Urologist

Dr Anouk Balster

Dr Nina Su Paediatric Registrar

Dr Amy Rosario GPEP 3

Dr Hui Wang GP Wellington

Dr Susan Smith GP

Dr Katy Smith GP

Dr Penny Mcallum SMO Ophthalmologist

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Dr Debbie Harrison GP

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Dr. Johanne Egan, Emergency Medicine

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Dr Megan Higgins, General Practitioner

Dr Dasna Pallie, Specialist General Practitioner

Dr Rebecca Velluppillai, GP

Dr Sarah Marr, GP

Dr Fiona Miles, SMO Paediatric ICU, Starship Hospital

Dr Geetha Cox, Specialist GP

Dr Vicky Chaplin, GP and ED and Addiction Medicine MOSS

Dr Laura Gilding, GP and Hospice Doctor

Dr Emma McMenamin, Palliative Care SMO