A New Zealand Workforce Perspective

8th International Medical Workforce Conference

Glimpse of New Zealand

Male		1,903,200
Female		1,977,300
Total population:		3,880,500
Pakeha		80.1%
Maori		14.7%
Pacific peoples		6.5%
Asian		6.6%
Other		0.7%
Life expectancy	76.2 Male	81.0 Female
Fertility		2.0%
Infant mortality (per 1000 live births)		5.3%)

An average day in the health sector

- 157 babies are born
- 105,000 prescriptions are filled
- 40,000 laboratory tests are analysed
- 4,000 outpatients visit hospitals
- 432 people have elective surgery
- 1,960 people are seen in emergency departments
- 1,167 people are admitted to hospital
- 50,000 people take one of the new antidepressants
- 637 children are immunised
- 50,000 people visit a doctor.

New Zealanders abroad

Overseas experience (OE) is a birthright and rite of passage of young New Zealanders, enables upskilling but leads to 'brain drain'. A study showed of 2,180 young New Zealanders mainly 25 – 39.

- 40% in UK
- 27.4% in Australia
- 11% in USA.

75% mainly have degree or postgraduate qualification
39% stay away for 1 – 5 years.

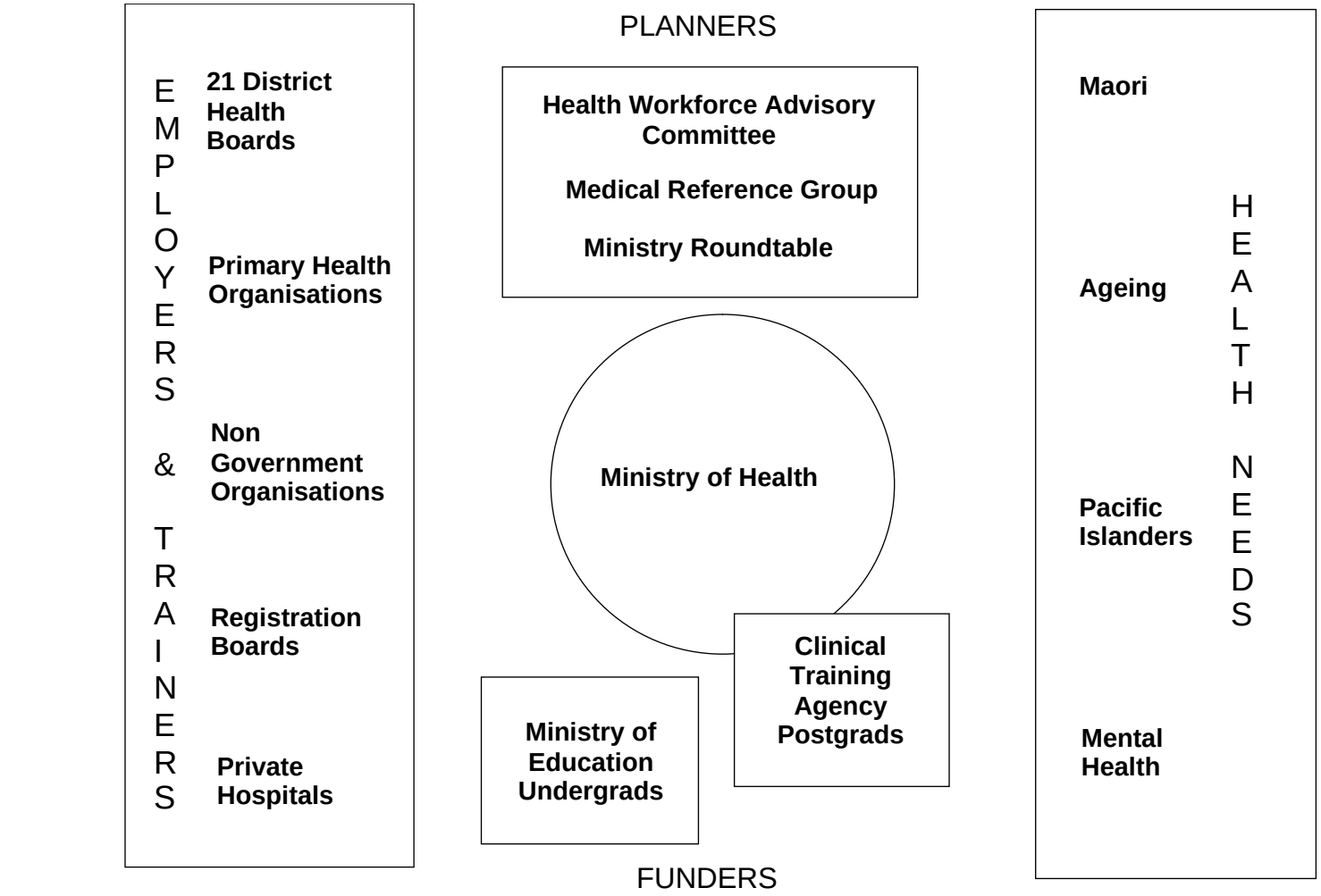
Leave for:

- salaries
- career opportunities
- challenge
- pay off student loan.

Return for:

- parents/older relations
- bring up children
- safety and security
- lifestyle.

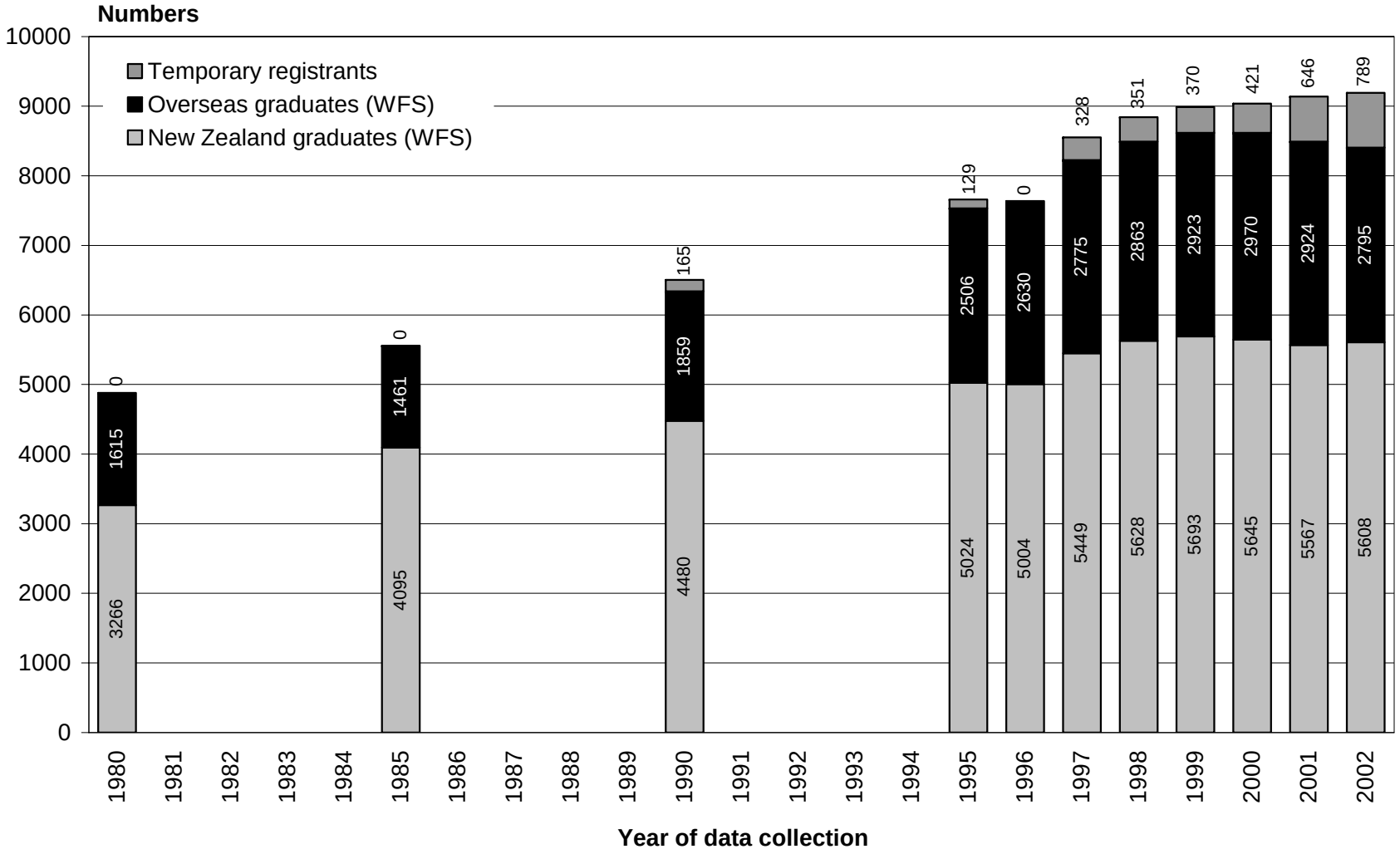
The Health Sector in New Zealand



Medical practitioners in NZ (2002)

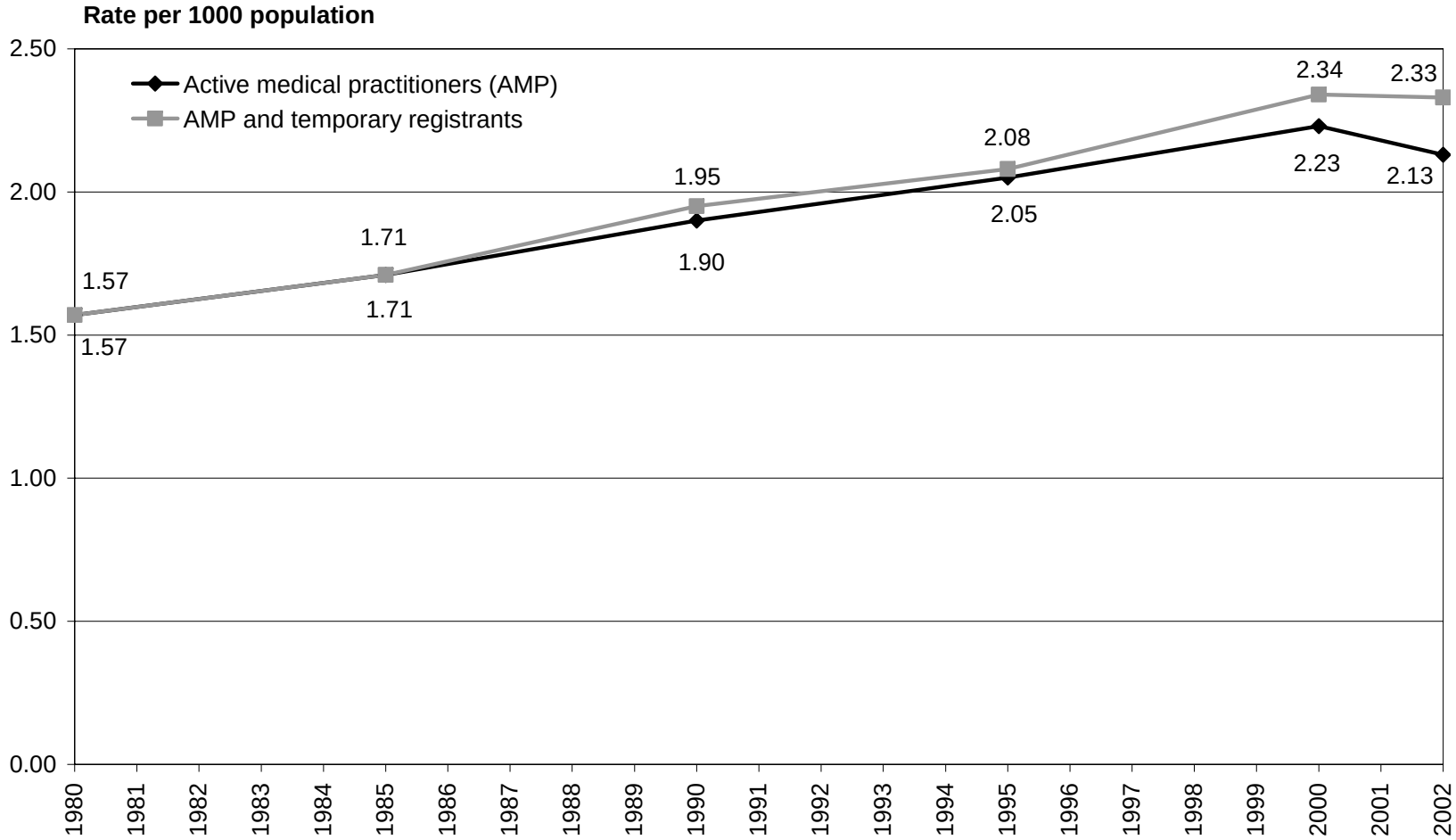
With APC	10,355
Number of actively practising doctors	8,403
Mean age	43 years
Proportion of women	34%
Overseas trained doctors	29.3% in 1990
Overseas trained doctors	33.3% in 2002
Overseas trained doctors and temporary doctors	40% in 2002
Maori	2.7%
Pacific Islander	1.0%

Figure 1: Active medical workforce 1980–2002



Source: MCNZ, 2004, The New Zealand Medical Workforce in 2002, Table 1.

Figure 2: Trends in the ratio of active medical practitioners (AMP) to population, 1980–2002



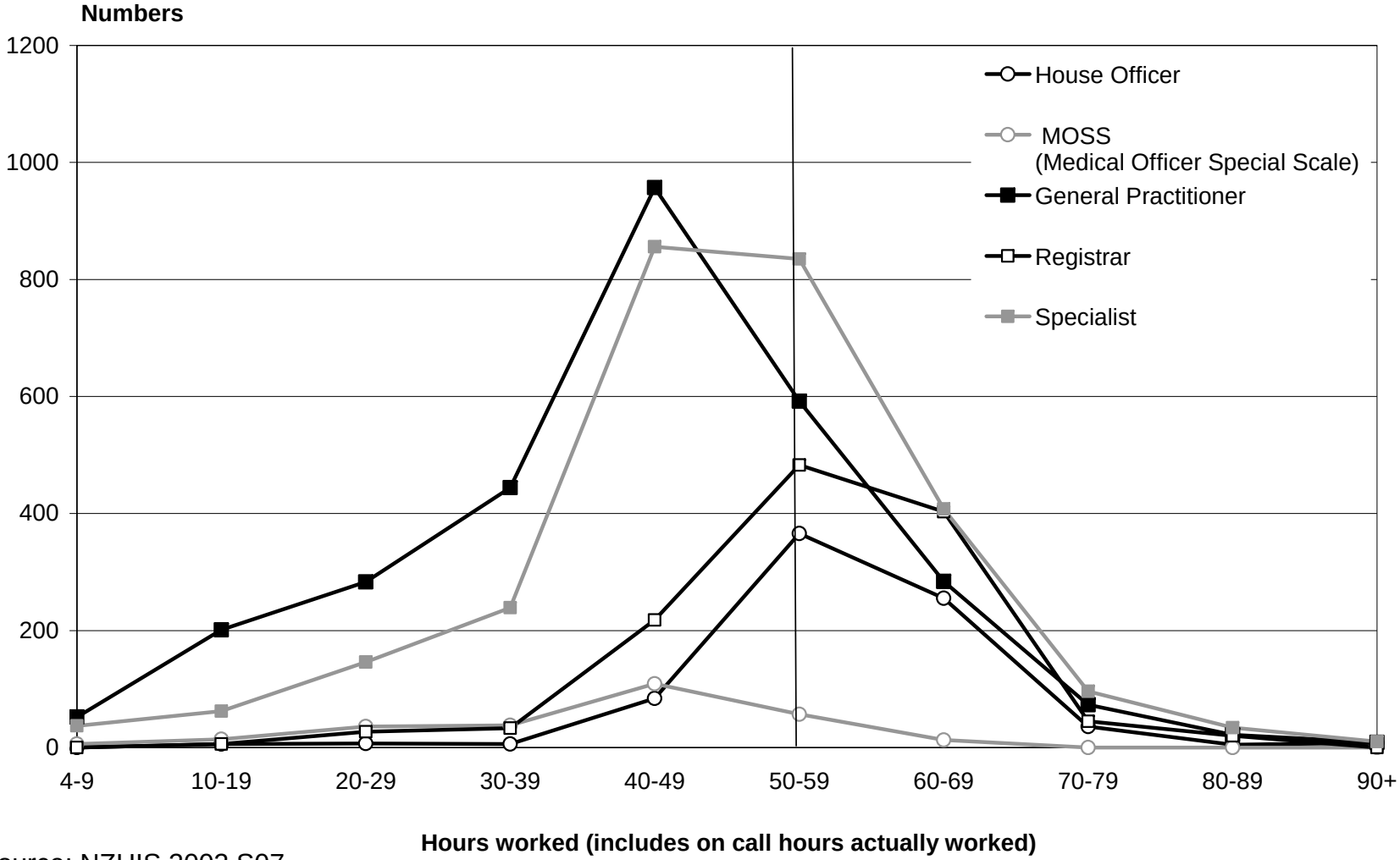
Source: Statistics New Zealand, MCNZ, 2004.

Medical practitioners in NZ (2002) cont'd

Changes in workforce

Up from 1995 by	4.9%
Up from 2000 by	2.6%
Down from 2001 by	1%
Decline in general practitioners	4.0%
Increase since 2000 in temporary registrants	64%

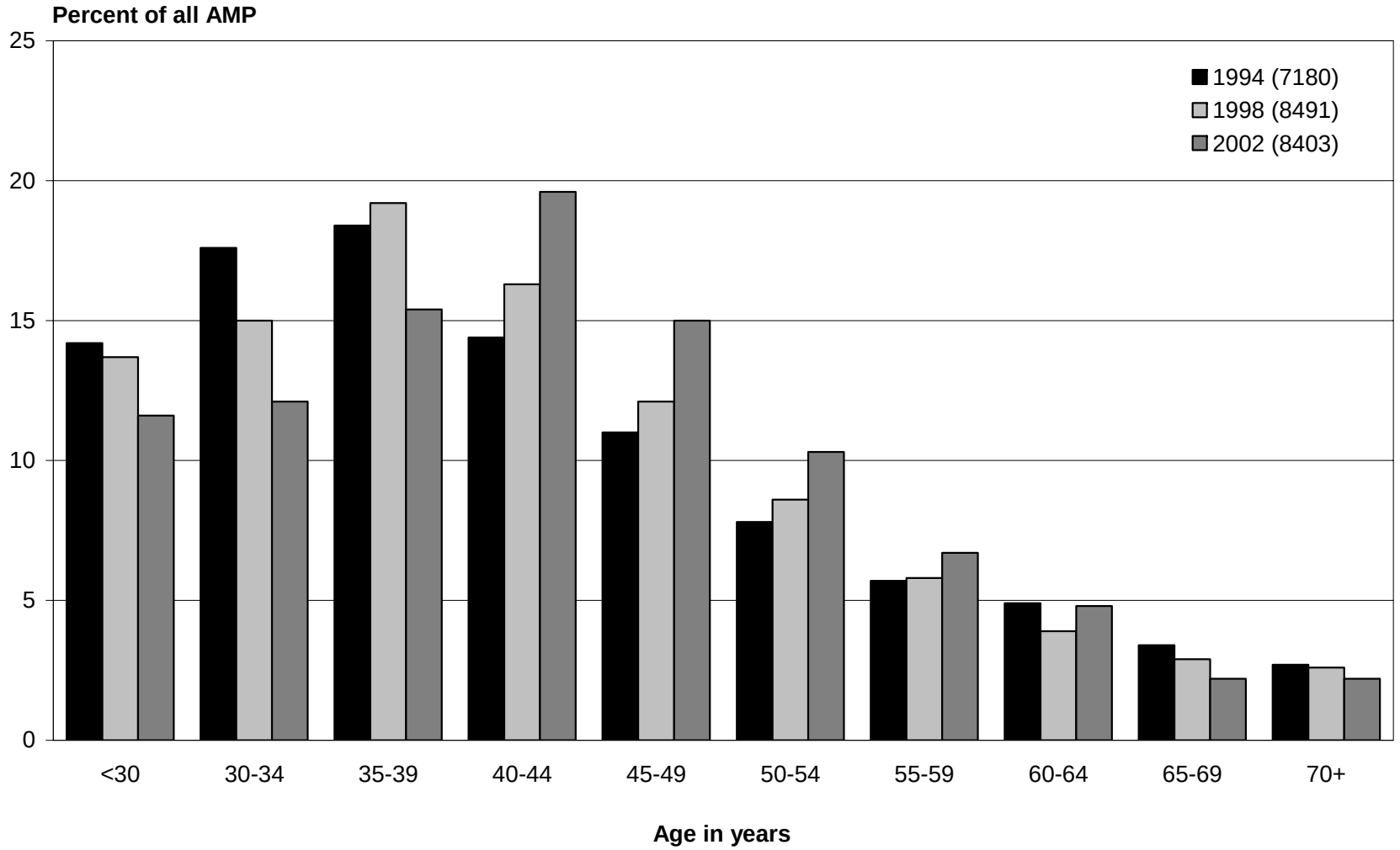
Figure 3: Total hours worked per week by work role 2002



Source: NZHIS 2002 S07

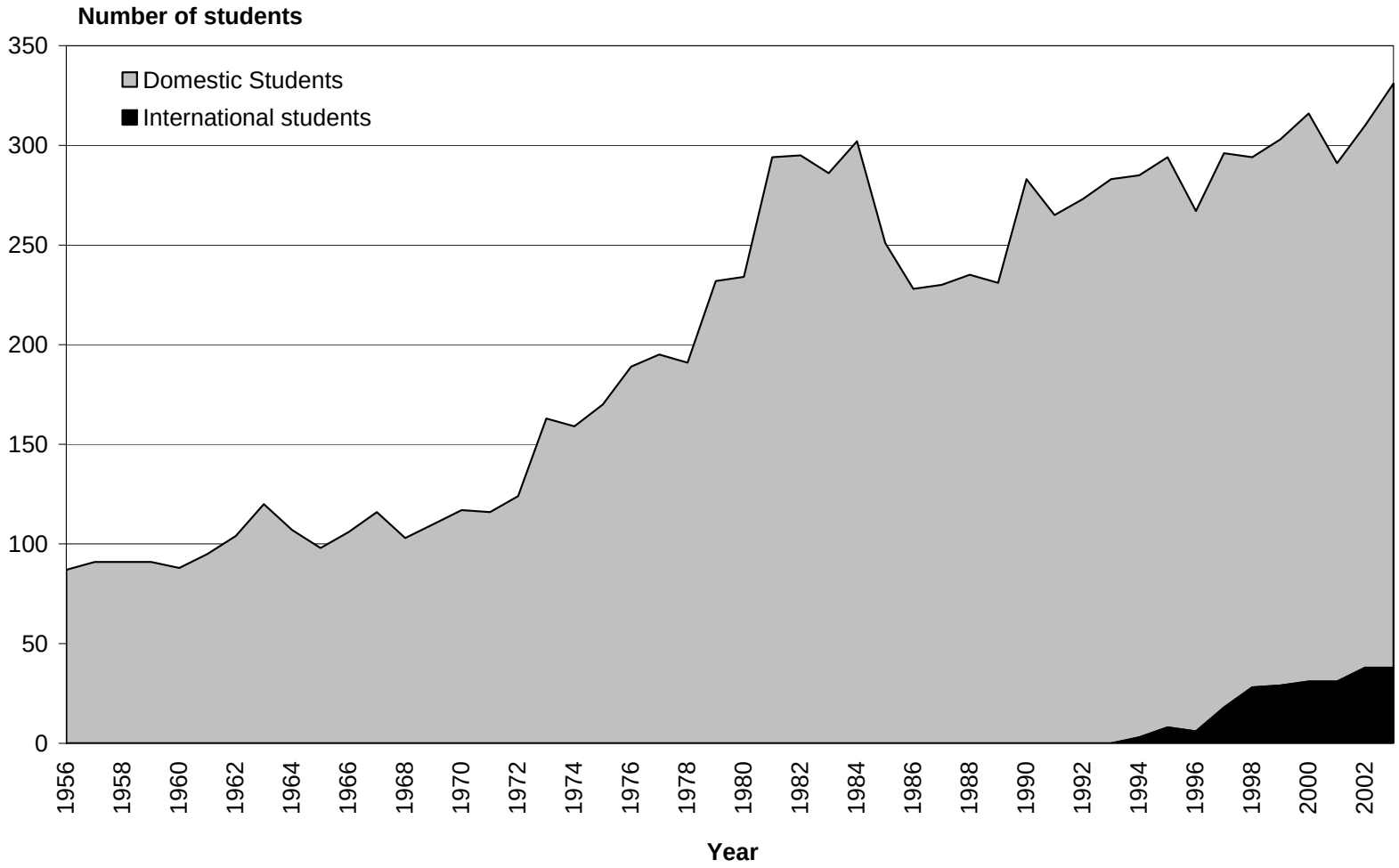
Note: Some practitioners recorded working 90+ hours per week indicating that hours on call but not actually worked may in some cases have been included in this category in error.

Figure 4: Active medical practitioners by age



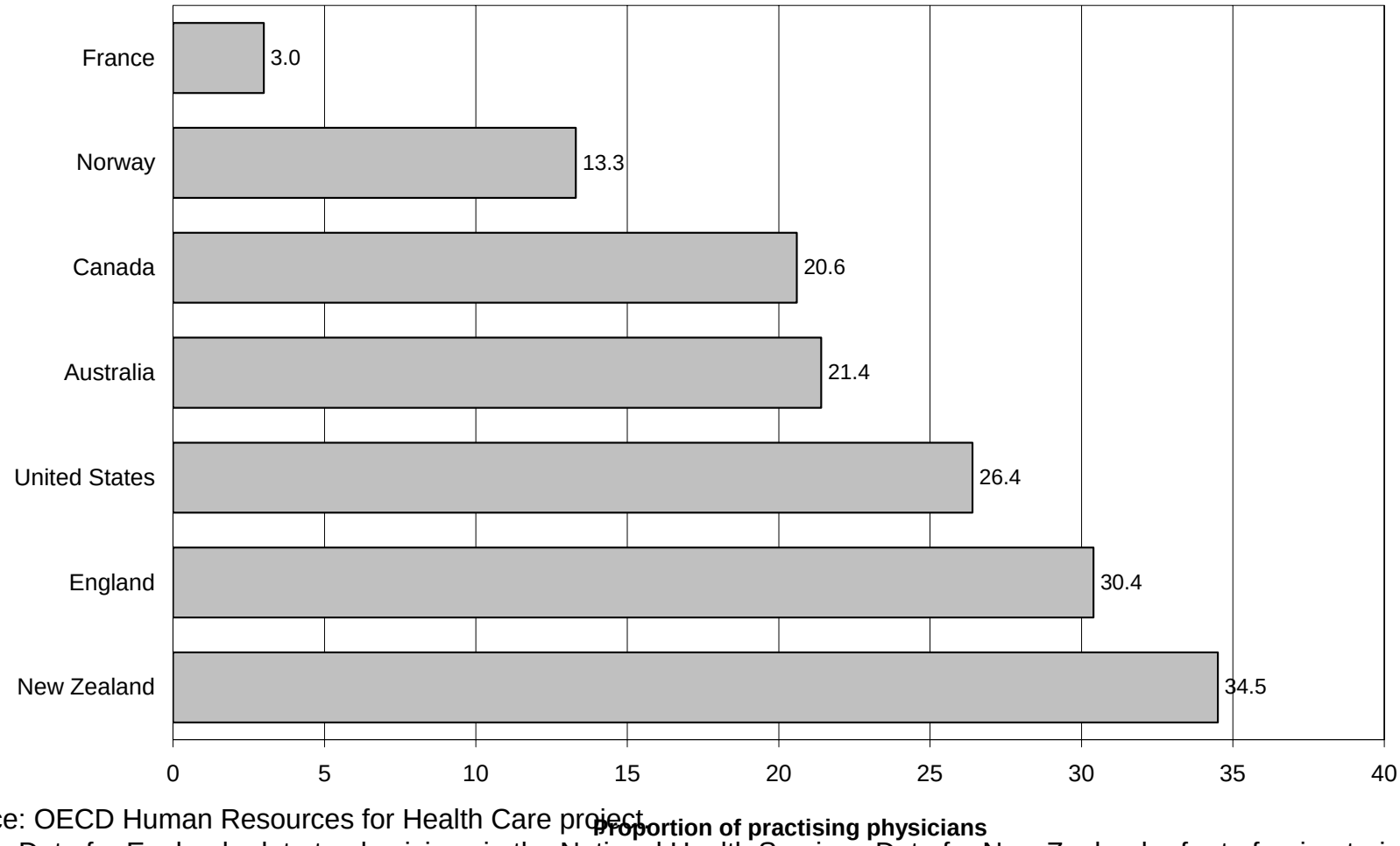
Source: NZHIS

Figure 5: MBChB graduates 1956–2003, domestic and international students



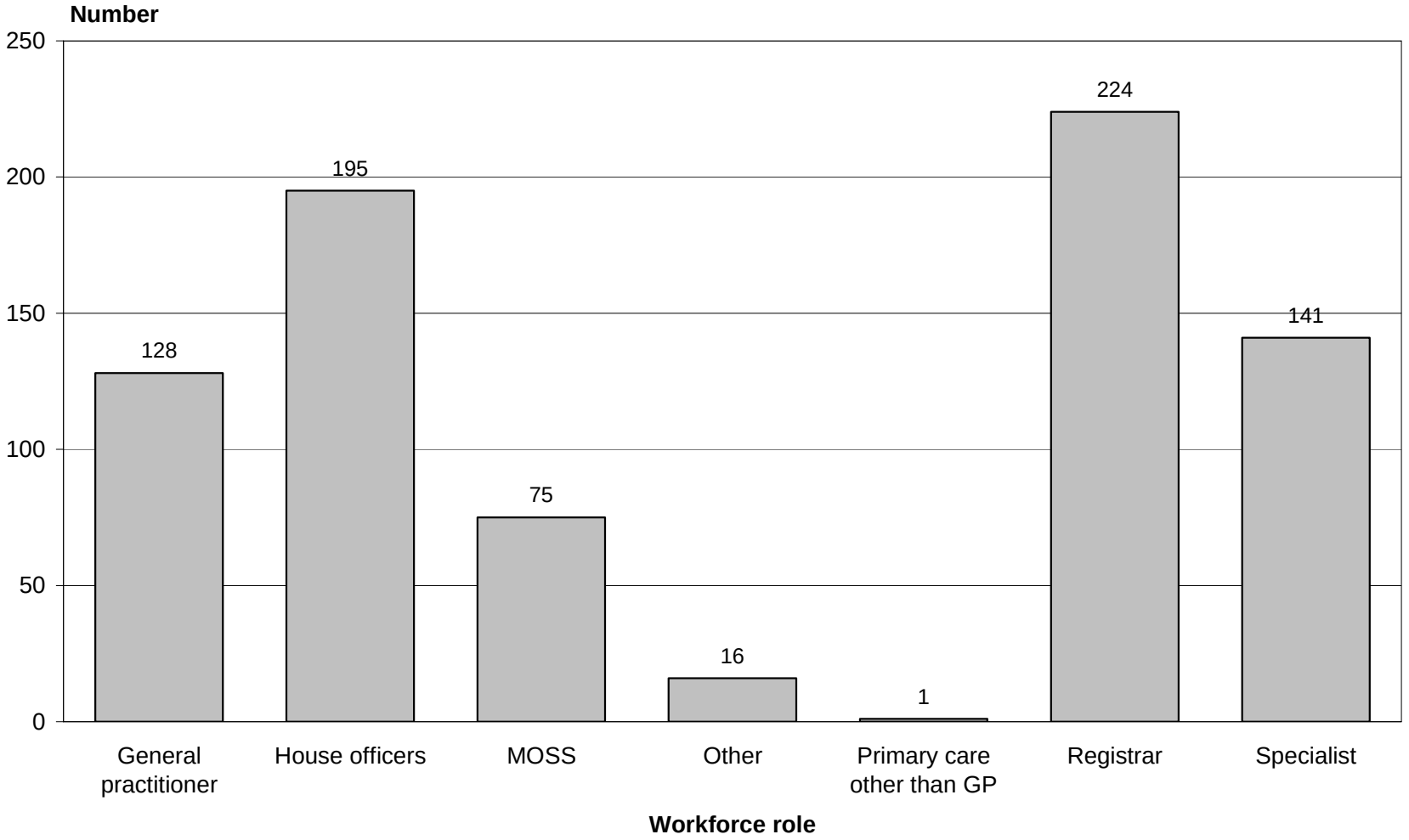
Sources: NZHIS, MCNZ, Ministry of Education, Auckland and Otago Medical Schools

Figure 6: Percentage of practising physicians who are foreign-trained, 2000



Source: OECD Human Resources for Health Care project.
Notes: Data for England relate to physicians in the National Health Service. Data for New Zealand refer to foreign-trained practising physicians.

Figure 7: Temporary registrants as at 19 January 2004 by workforce role



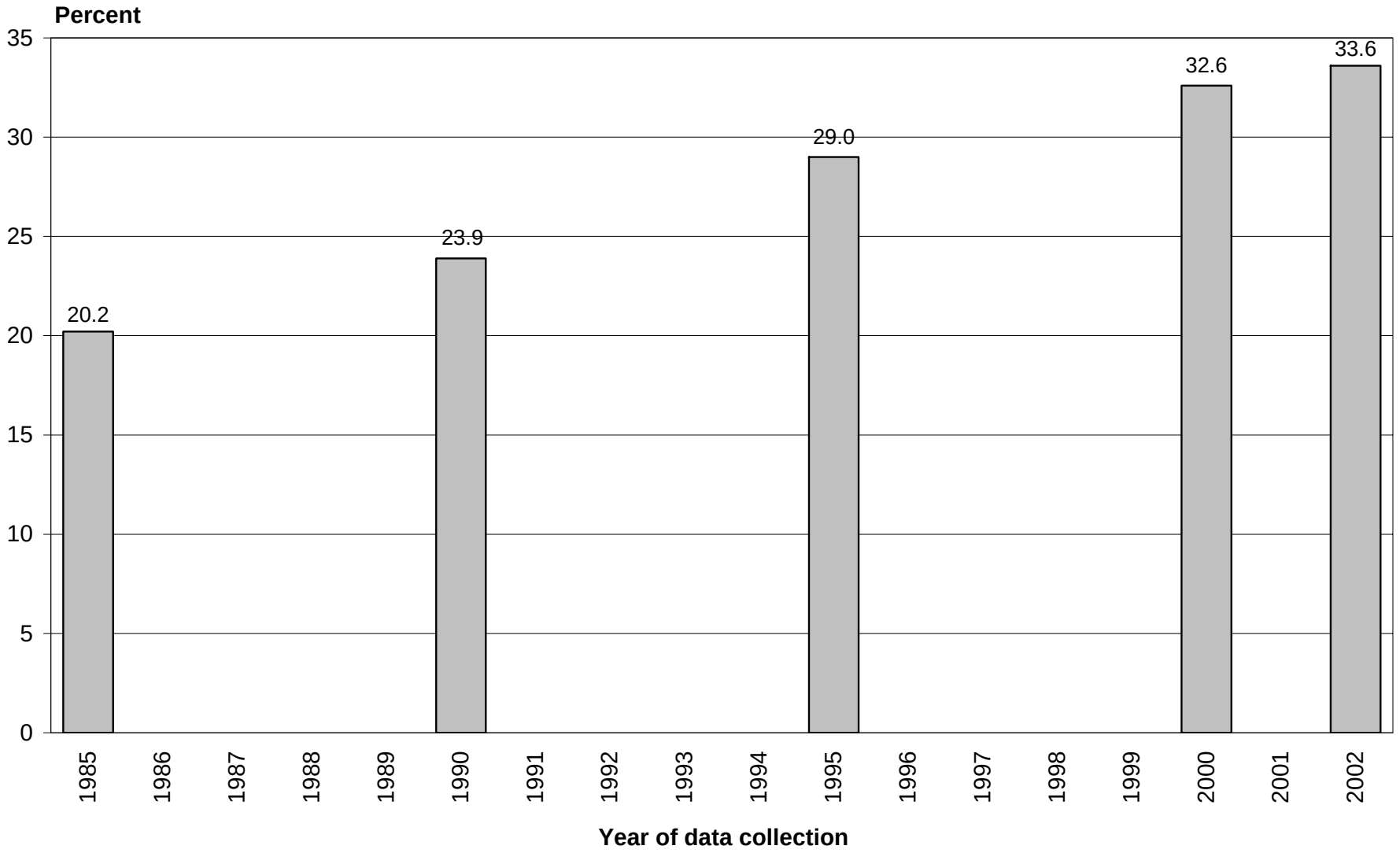
Source: MCNZ

Medical practitioners in NZ (2002) cont'd

Changes include:

- decrease in hours worked
- increase in average age
- increased student debt
- graduate retention decrease
- mal-distribution especially in general practice
- reliance on overseas trained doctors
- Medical Council registration policies.

Figure 8: Females as a percentage of active medical practitioners



Medical practitioners in NZ (2002) cont'd

In 2002, 39 percent of registrars, 38 percent of general practitioners and 20 percent of specialists were women (MCNZ 2004b).

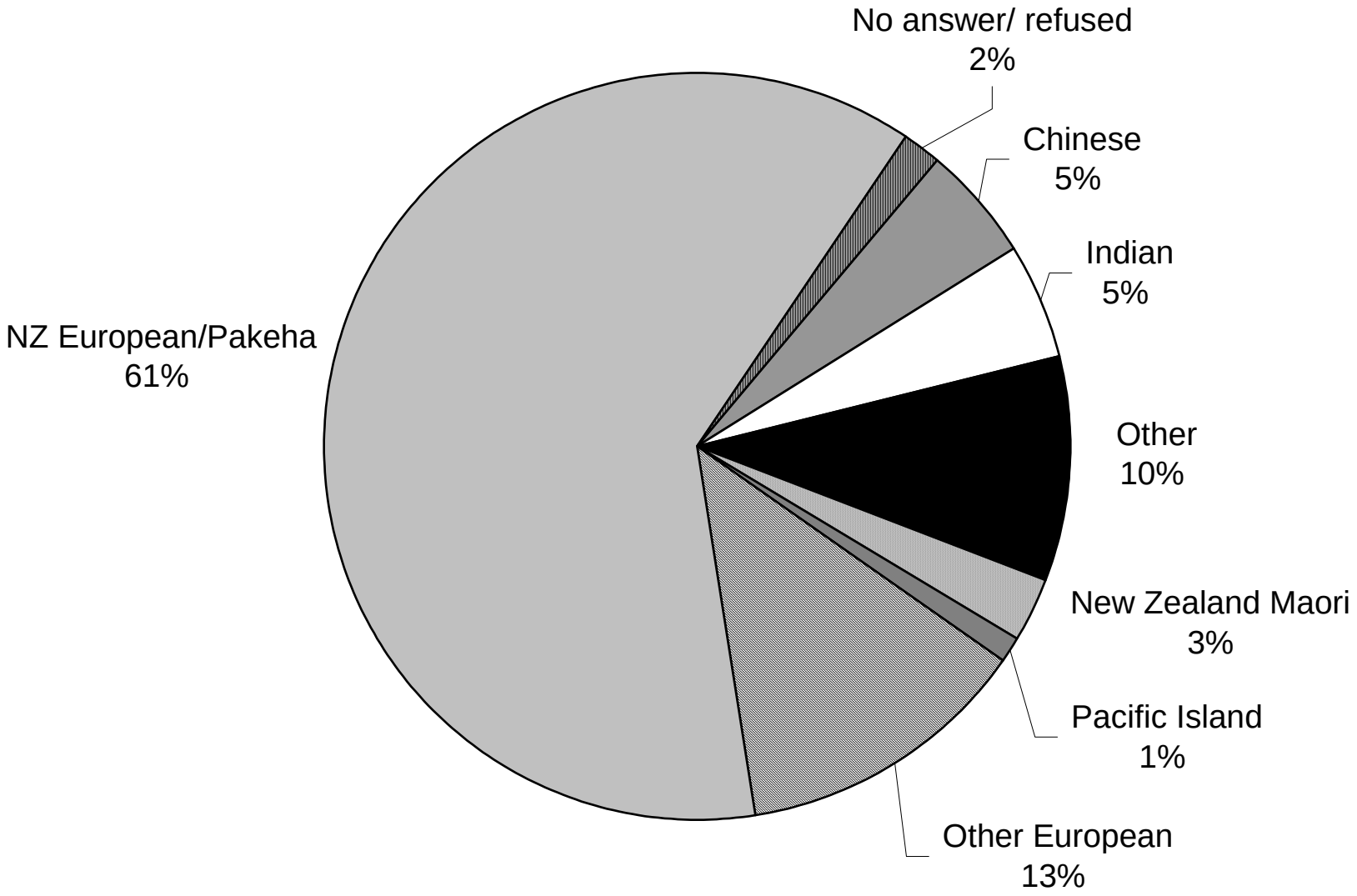
The following characterise the female medical workforce:

- steady growth towards 50 percent of the workforce
- interest in family and in work/life balance
- flexible, part time training and work arrangements
- preference for well organised salaried employment
- vocational interest in general practice, primary care and public health.

Workforce policy in NZ

1970	Medical Council data collection
1976	Medical planning conference
1985	National conference on role of doctor
1986	Ministerial Advisory Committee set up
1980/90	Reforms in health sector and lack of planning
2000	Return to workforce policy development
2003	Health Practitioners Competence Assurance Act

Figure 9: Ethnicity of active medical practitioners



Source: NZHIS 2002

External factors to be addressed

- The level of chronic disease will rise substantially.
- The population to grow to 4.8 million in 2046 then to decline slowly.
- In 2021 Maori are expected to be 17%, Pacific peoples 9%, Asians 13%.
- 39% of public spending on health services is on persons over 65 years,
- 26% on persons over 75 years.
- Labour force is expected to grow slowly over the next 20 years.

Public concerns

- Availability and cost of care.
- Concern about quality of care.
- Wasteful use of scarce resources.
- Lack of continuity of care for patients.
- Fragmented teamwork and poor staff relationships.
- Reduced safety for patients and doctors.

Public expectations

- Want a more informed and informative service.
- Convenient and affordable access.
- More care delivered in community settings.
- Management of chronic disease and disability.
- Greater specialisation and greater medical input.

Doctors' perceptions

- Poor structures and processes inhibit a full professional contribution.
- Pressures arise from existing doctor shortages.
- Concern about student loans and retention.
- Lack of clarity about roles and responsibilities, particularly as flexible team working becomes more of an imperative.

Doctors' perceptions cont'd

- Perceived poor remuneration compared with international marketplace.
- The demands of bureaucracy and management.
- Lack of vocational guidance and mentoring.
- Perceived lack of training.
- Lack of peer support in rural and provincial settings.

Doctors' expectations

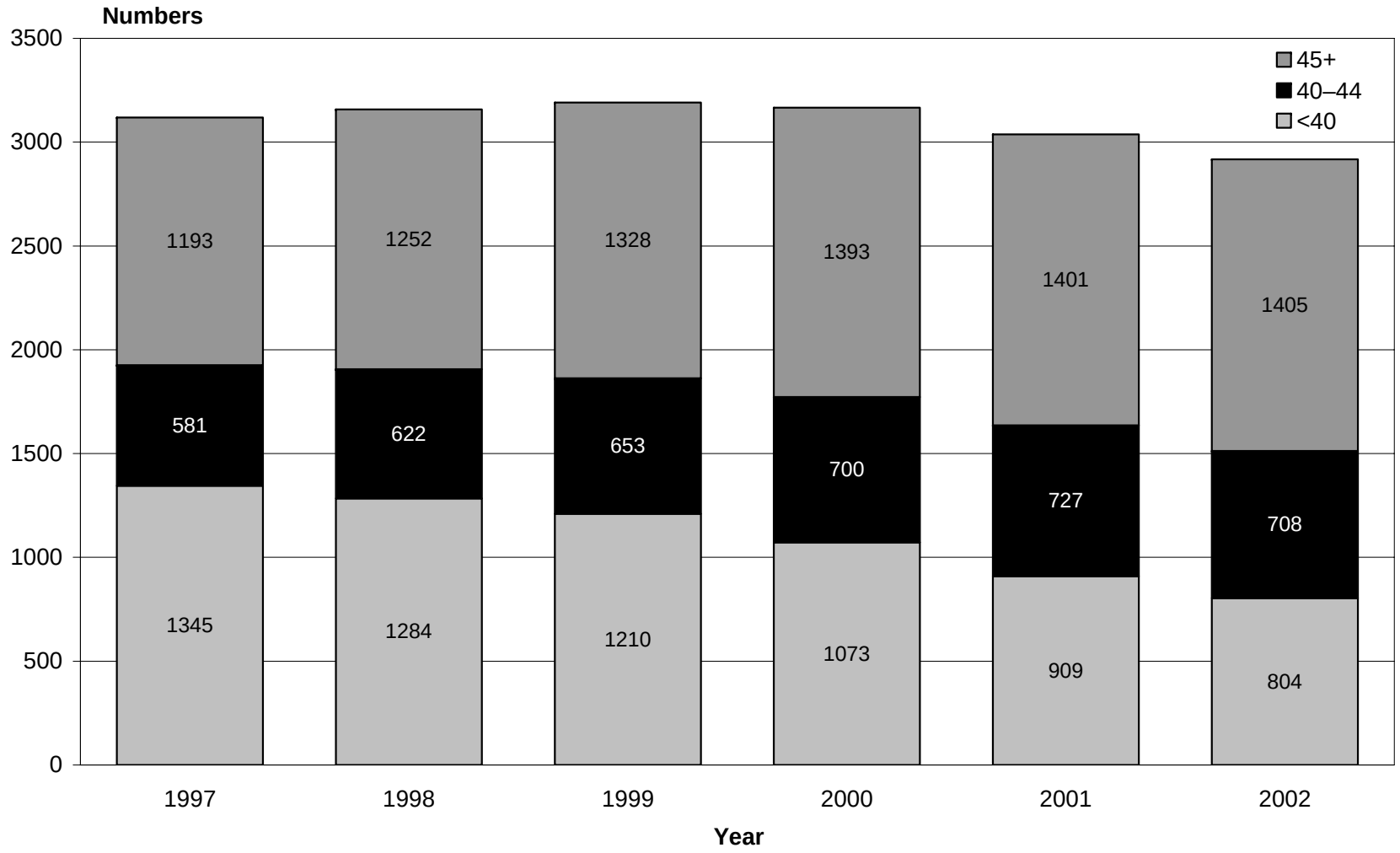
- Reasonable working hours and patterns of work.
- A clear, secure and flexible framework for career progression.

Perceptions about work in primary care

Medical graduates are not choosing general practice in a rural setting as a career option because:

- on-call workload
- partner's career aspirations
- family concerns and lifestyle choices
- financial constraints
- student urban origin
- lack of a robust locum service
- the extensive skill base required.

Figure 10: Decrease in number of younger general practitioners



Source: NZHIS E21

Solutions – ‘set up a committee’ !

- Health Workforce Advisory Committee
- Medical reference group
- Minister’s round table
- Ministry of Health
- Tertiary Education Committee
- District Health Boards’ work plan
- Medical Council of New Zealand
- International Association of Medical Regulatory Authorities (IAMRA)

Health Workforce Advisory Committee (HWAC)

HWAC found:

- a degraded structure to support health workforce planning and development
- an inadequate information base in most respects
- poor communication and cooperation between stakeholders
- narrow, siloed thinking in work settings and occupational areas
- unhealthy and sometimes dysfunctional work environments
- little trust in political, managerial and professional health leadership.

Medical reference group (MRG) concerns

- The complex nature of the health/medical workforce planning environment.
- Continuing problems in data collection and analysis and in information sharing.
- Lack of an informed, inclusive, open and sustained national dialogue.

Medical reference group (MRG) concerns cont'd

- The impact of changing political ideologies leading to repeated restructuring.
- Lack of an infrastructure to guide and integrate health and medical workforce planning.
- Dependence on occasional reviews, ad hoc special interest advocacy, and political expediency.

MRG solutions for the sector as a whole

- Planning should start now and have at least a 10 year horizon.
- Social trends and public expectations can be influenced.
- Medical and technical advances can have a dramatic impact, and in a short timescale.
- There needs to be greater equity and social justice in the allocation and use of all health resources.
- Clarify postgraduate medical education funding and health/education interface.

Solutions – flexible employment

More flexible employment arrangements would:

- ensure a more responsive medical workforce better able to respond to service need
- include more part time and job sharing arrangements
- support recruitment and retention
- meet individual doctor needs
- improve career development.

Solutions – retention

- Maintain management that is supportive of quality service delivery.
- Ongoing professional development and safe hours.
- Ensure changes in health structures are evolutionary and transparent.
- Address the impact of student loans.
- Encouragement for District Health Boards to take a longer term view on employment.
- Training for human resource staff at DHBs.

Solutions – recruitment

- Selection and training of medical students.
- Vocational guidance and career development.
- The financing of medical education, including student debt.
- The organisation, funding and allocation of training posts.
- The design, funding and use of incentive schemes of benefit to doctors, and the health system.

Solutions – Ministry of Health

Concentrate on building primary health workforce:

- take a population health approach
- address health inequalities
- involve consumers, service providers and local communities
- coordinate service delivery around the needs of enrolled populations
- have a not-for-profit structure with accountability for the use of public funds and for the safety and quality of services (PHOs)
- complete a discussion paper on workforce responses to an ageing population.

Solutions – TEC

- Complete an analysis of the current provision of education and clinical training – the cost, who pays, to inform policy development.
- Develop and implement workforce action strategies.
- Improve the Ministry's workforce information.
- Support DHBs in implementing their Workforce Action Plan.
- Support the Health Workforce Advisory Committee.
- Undertake research on the barriers and incentives to Maori participation in the health workforce.

Solutions – Medical Council

"Home grown" doctors are best, therefore need strategies to:

- increase recruitment and retention
- reduce student debt
- encourage postgraduate training
- reduce senior burnout.

Solutions – Medical Council cont'd

Overseas trained doctors are a significant part of workforce and therefore must have:

- induction and orientation
- cultural competence programmes
- bridging programmes
- ready for work programmes.

Solutions – Medical Council cont'd

Employers need to:

- take a longer term view of employment strategies
- provide assessment and upskilling posts
- facilitate support supervision and recertification.

Solutions – Medical Council cont'd

- Implementation of innovative registration pathways.
- Use of provisional registration pathways.
- Ensuring competence through involvement from intern year to retirement.
- Accreditation of medical schools
- Accreditation of providers of postgraduate education and MOPS.
- Need to review of the apprenticeship model.

Solutions via International Association of Medical Regulatory Authorities

- “Passport” project and CGS international exchange.
- International exchange of information.
- International screening examination.
- WHO project on medical regulation worldwide.
- Research on medical practice migration patterns.

Overall

- Building a learning sector.
- Address education/health interface.
- Review service and training arrangements.
- Use registration authorities to define scopes of practice.
- Develop sector leadership.
- Focus on primary health care.
- Improve national, regional and local planning and coordination.

Agreement on….

The starting point for medical/health workforce development should be a clear, shared, strategic vision with coordinated policy development.

THANK YOU

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Medical Council of New Zealand website: www.mcnz.org.nz

IAMRA website: www.iamra.com