A New Zealand Workforce Perspective

8th International Medical Workforce Conference

Glimpse of New Zealand

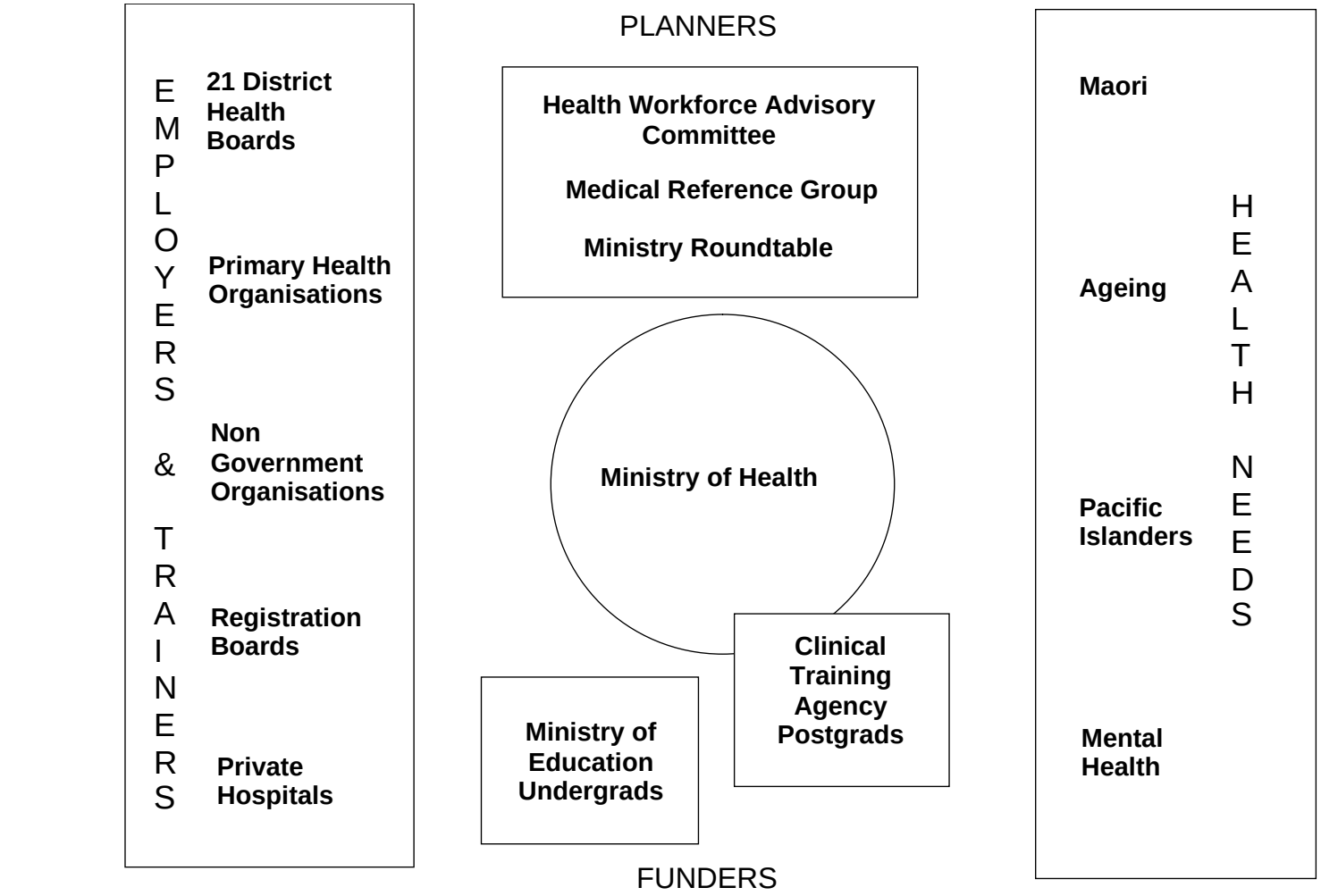
Male		1,903,200
Female		1,977,300
Total population:		3,880,500
Pakeha		80.1%
Maori		14.7%
Pacific peoples		6.5%
Asian		6.6%
Other		0.7%
Life expectancy	76.2 Male	81.0 Female
Fertility		2.0%
Infant mortality (per 1000 live births)		5.3%

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.


Scandinavia
United Kingdom
Russia
Alaska
Canada
Central Europe
USA
Korea
Japan
China
Israel
Iran
Algeria
Libya
Egypt
Saudi Arabia
India
Taiwan
Hong Kong
Mexico
Hawaii
Sudan
United Arab Emirates
Philippines
Thailand
Malaysia
Singapore
Colombia
Indonesia
Brazil
Peru
Fiji
Australia
South Africa
Chile
Argentina
Tasmania
New Zealand
Antarctica

The Health Sector in New Zealand

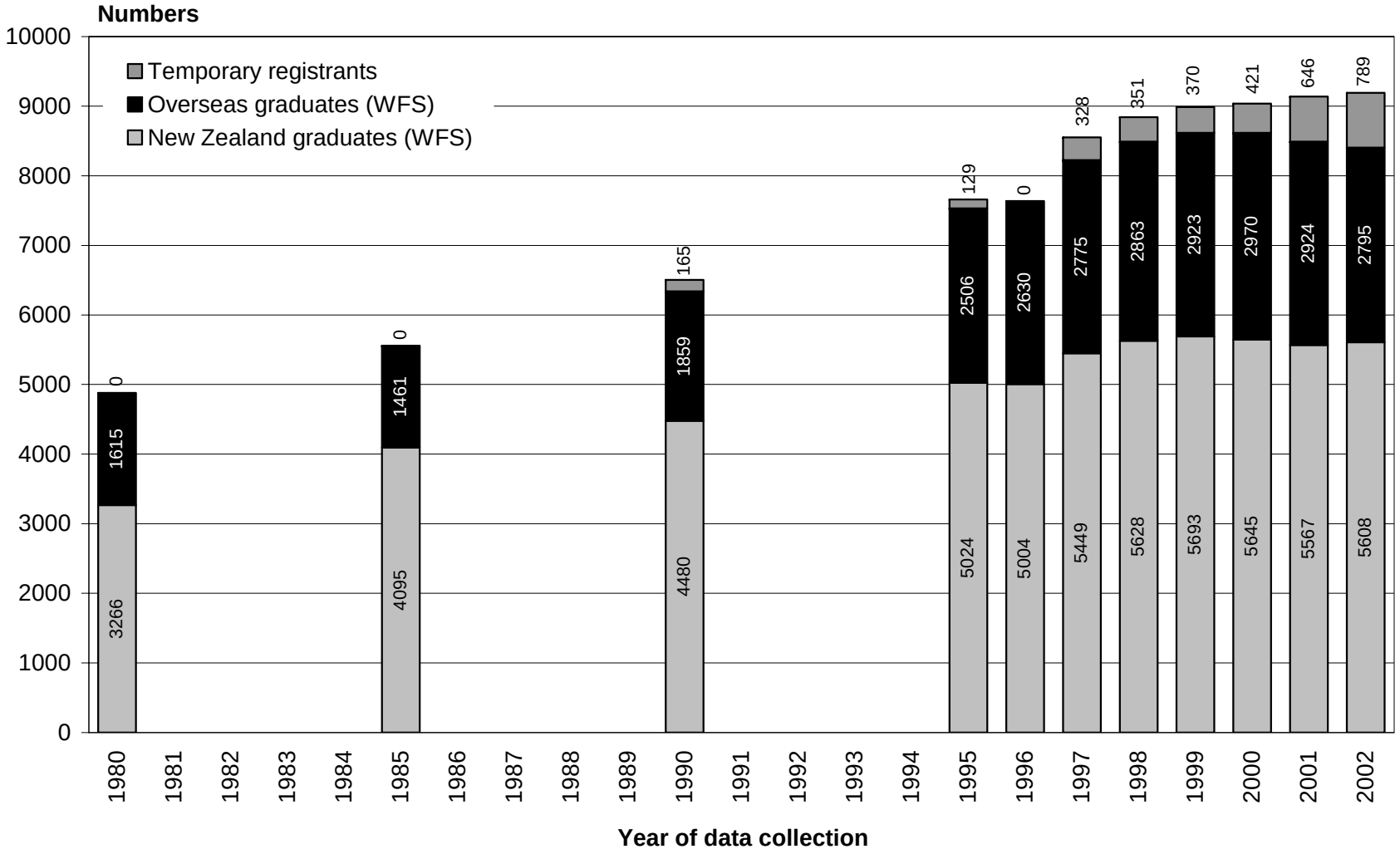


Medical practitioners in NZ (2002)

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%

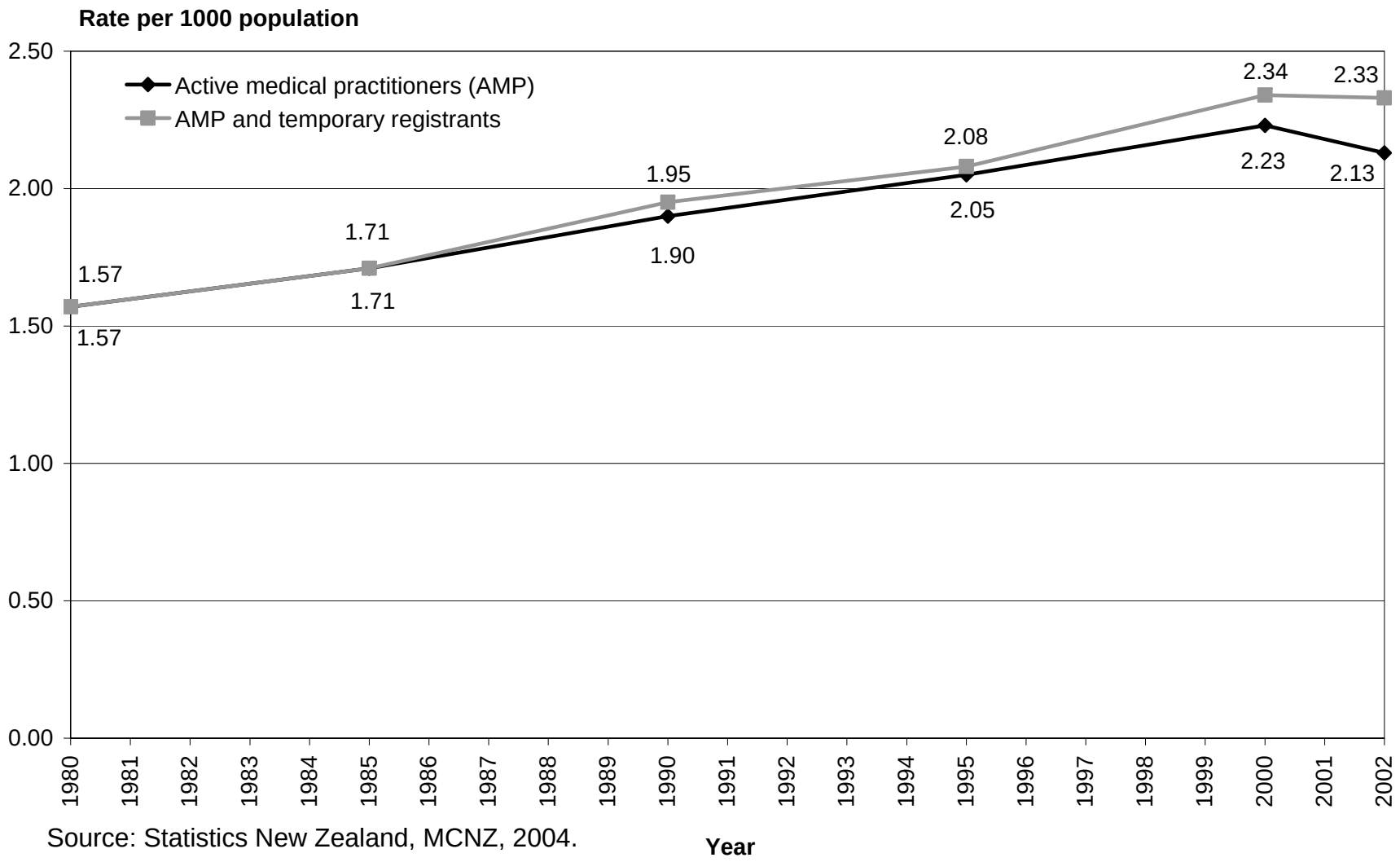

Kaitaia
Kerikeri
Bay of Islands
Kaikohe
WHANGAREI
Dargaville
Warkworth
Orewa
Helensville
North Shore
AUCKLAND
Papatoetoe
Manurewa
Papakura
Thames
Pukekohe
HAMILTON
TAURANGA
Whakatane
Waitomo Caves
Tokoroa
ROTORUA
Te Kuiti
Taupo
Gisborne
Taumarunui
NEW PLYMOUTH
Wairoa
Hawera
NAPIER
HASTINGS
WANGANUI
Feilding
Dannevirke
PALMERSTON NORTH
Golden Bay
Levin
Paraparaumu
Upper Hutt
Masterton
Motueka
Porirua
Lower Hutt
Picton
NELSON
Blenheim
WELLINGTON
Westport
Greymouth
Kaikoura
Rangiora
Franz Josef Glacier/Waiau
CHRISTCHURCH
Aoraki/Mount Cook
Ashburton
Timaru
Milford Sound
Wanaka
Queenstown
Oamaru
Alexandra
Te Anau
DUNEDIN
Gore
Balclutha
INVERCARGILL
Stewart Island/Rakiura

Figure 1: Active medical workforce 1980–2002



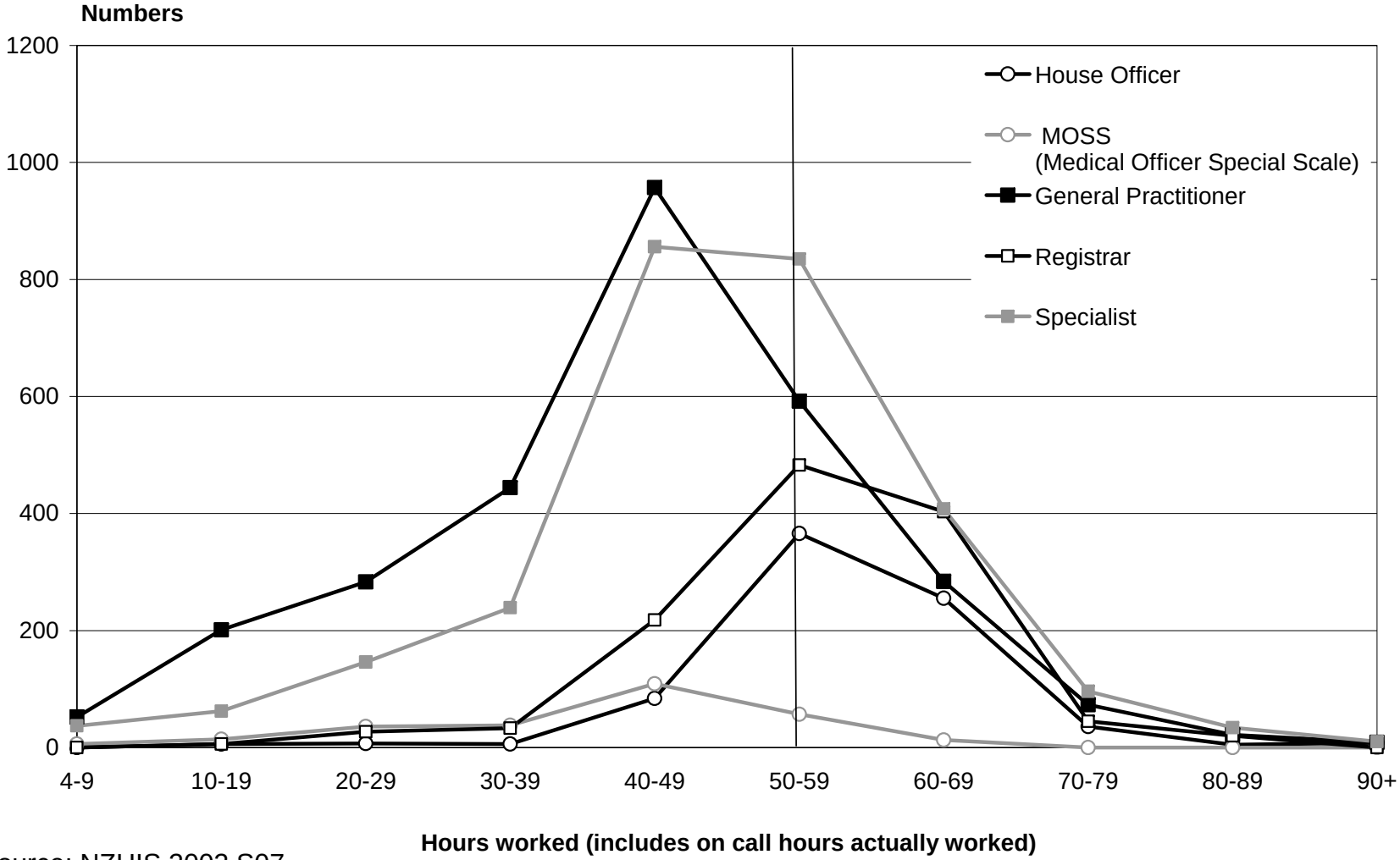
Source: MCNZ, 2004, The New Zealand Medical Workforce in 2002, Table 1.

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



Source: Statistics New Zealand, MCNZ, 2004.

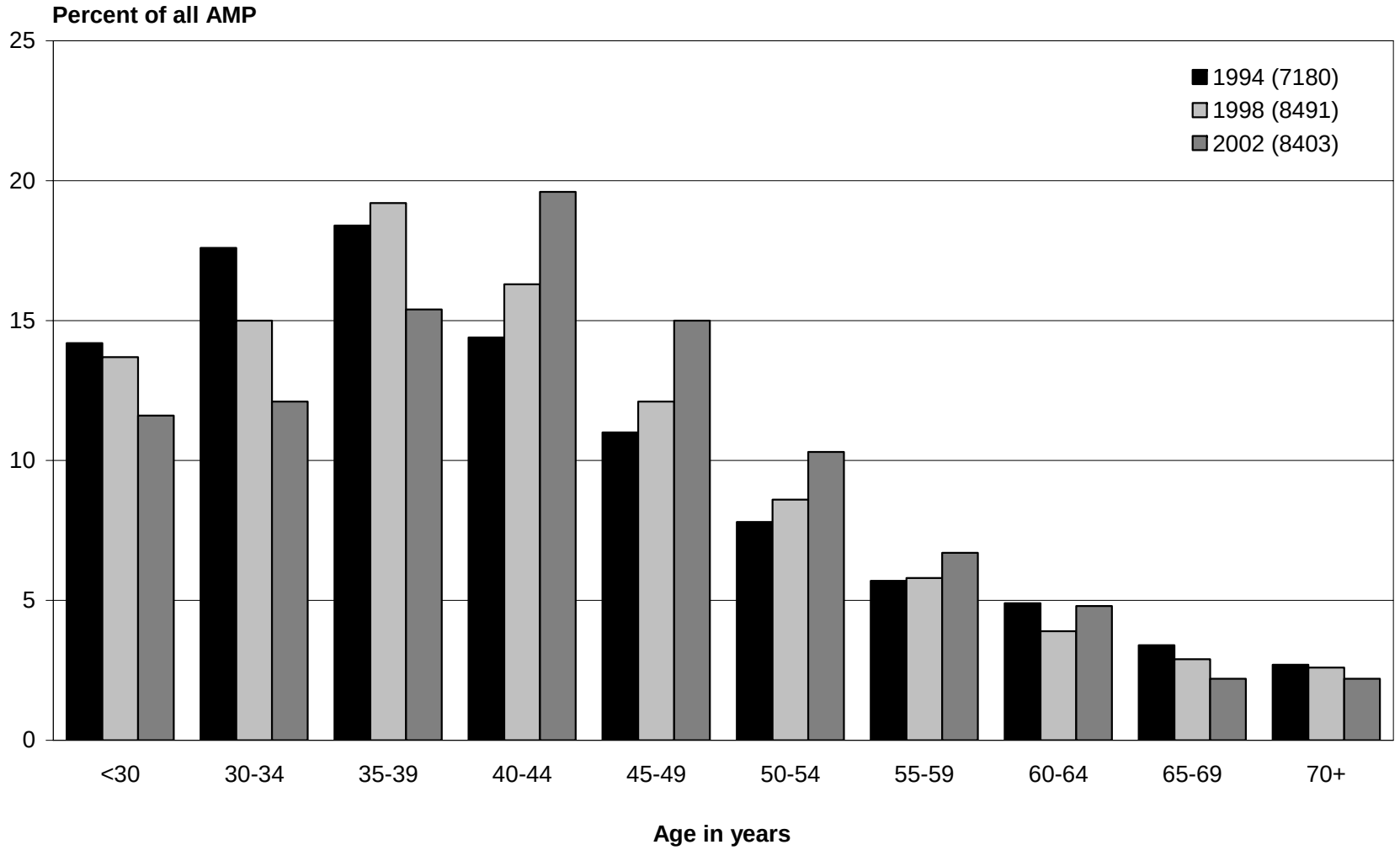
Figure 3: Total hours worked per week by work role 2002



Source: NZHIS 2002 S07

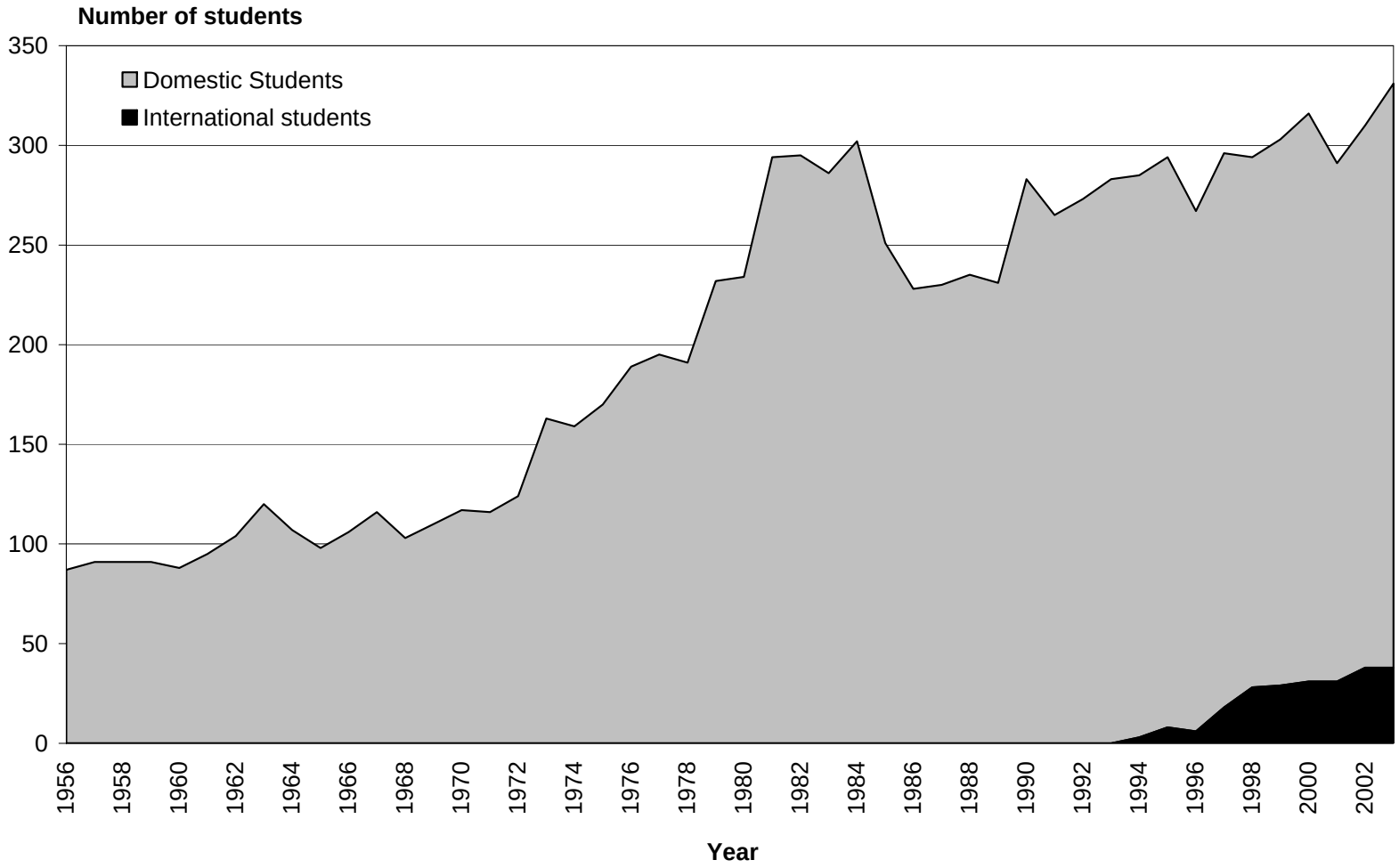
Note: Some practitioners recorded working 90+ hours per week indicating that hours on call but not actually worked may in some cases have been included in this category in error.

Figure 4: Active medical practitioners by age



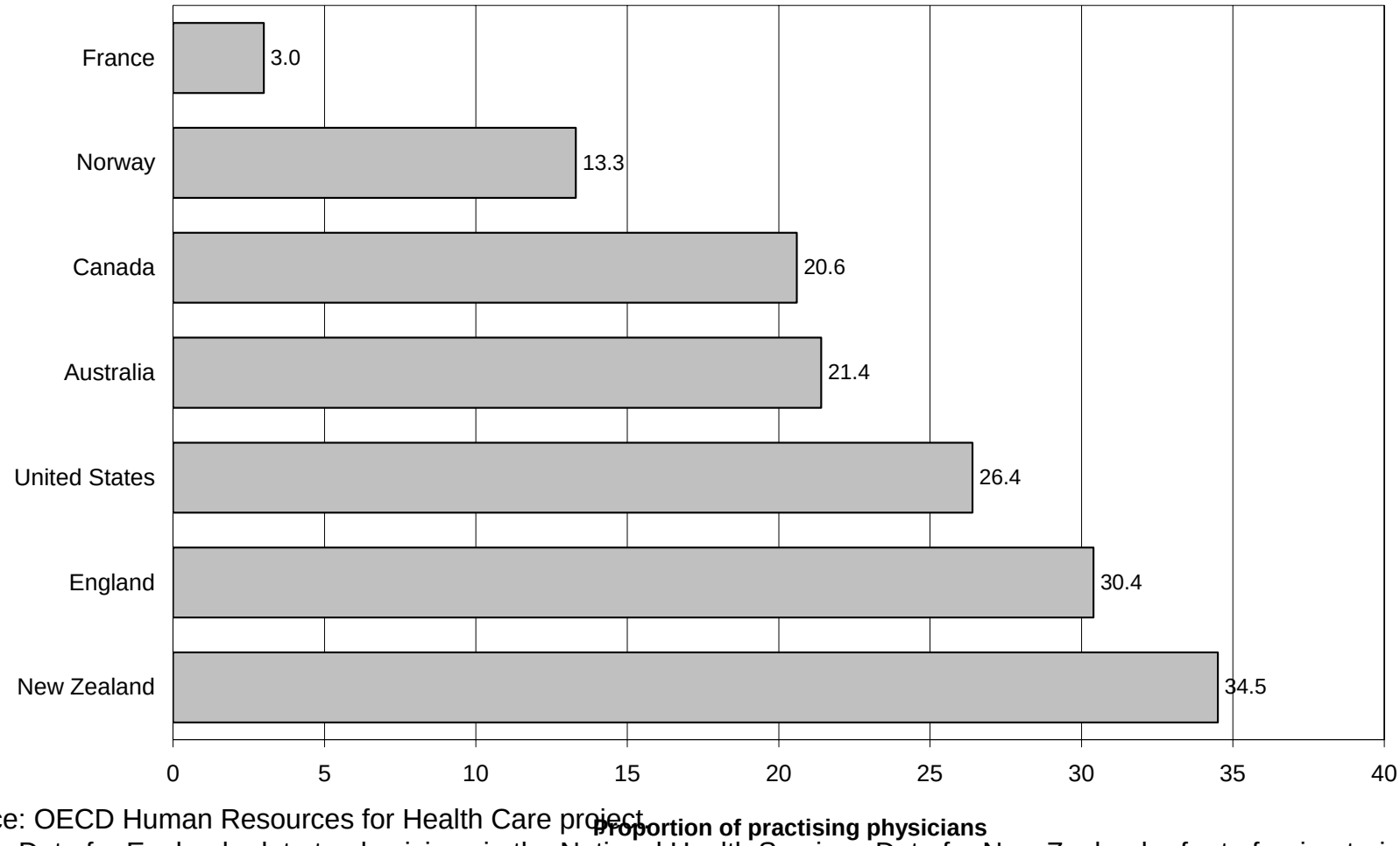
Source: NZHIS

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



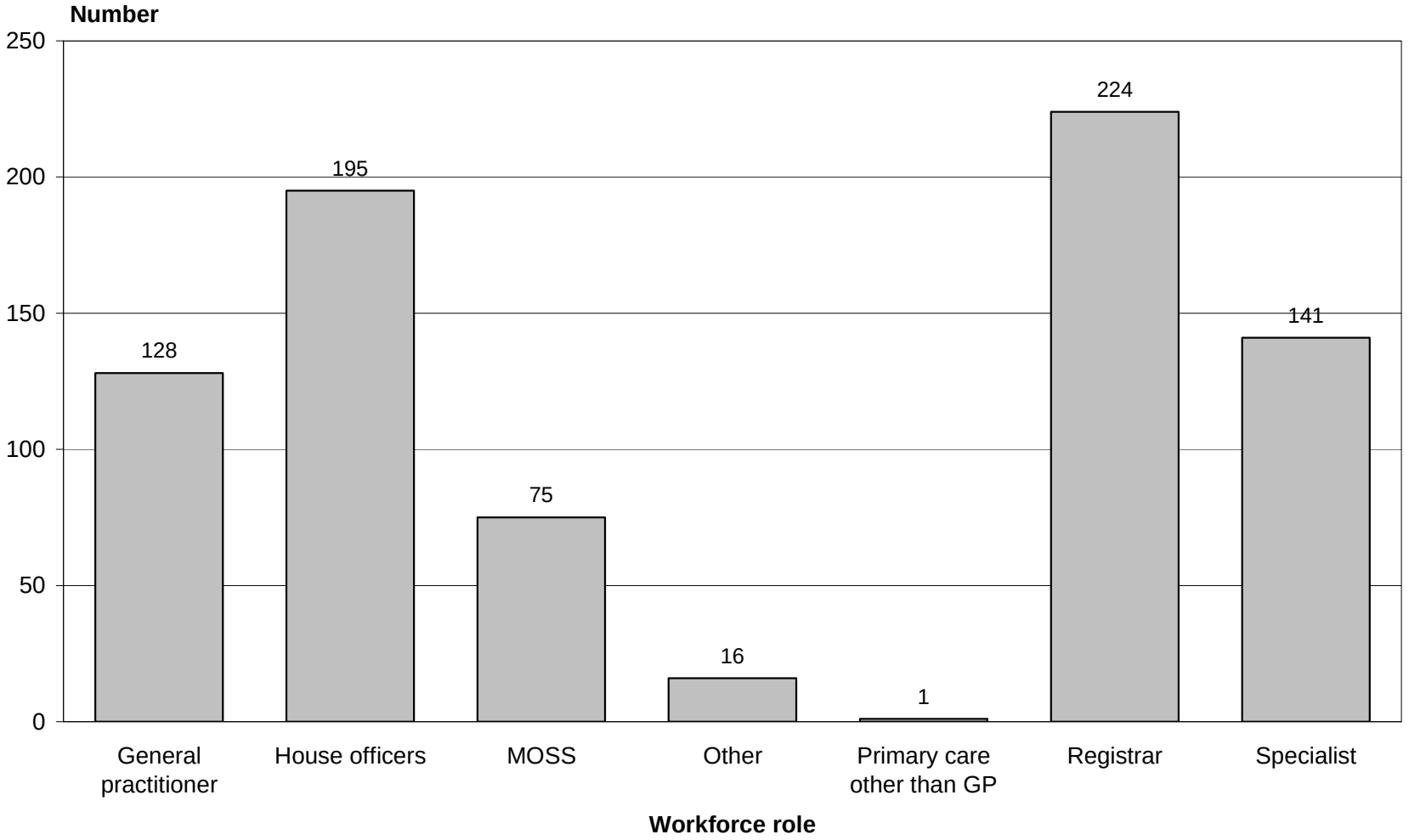
Sources: NZHIS, MCNZ, Ministry of Education, Auckland and Otago Medical Schools

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



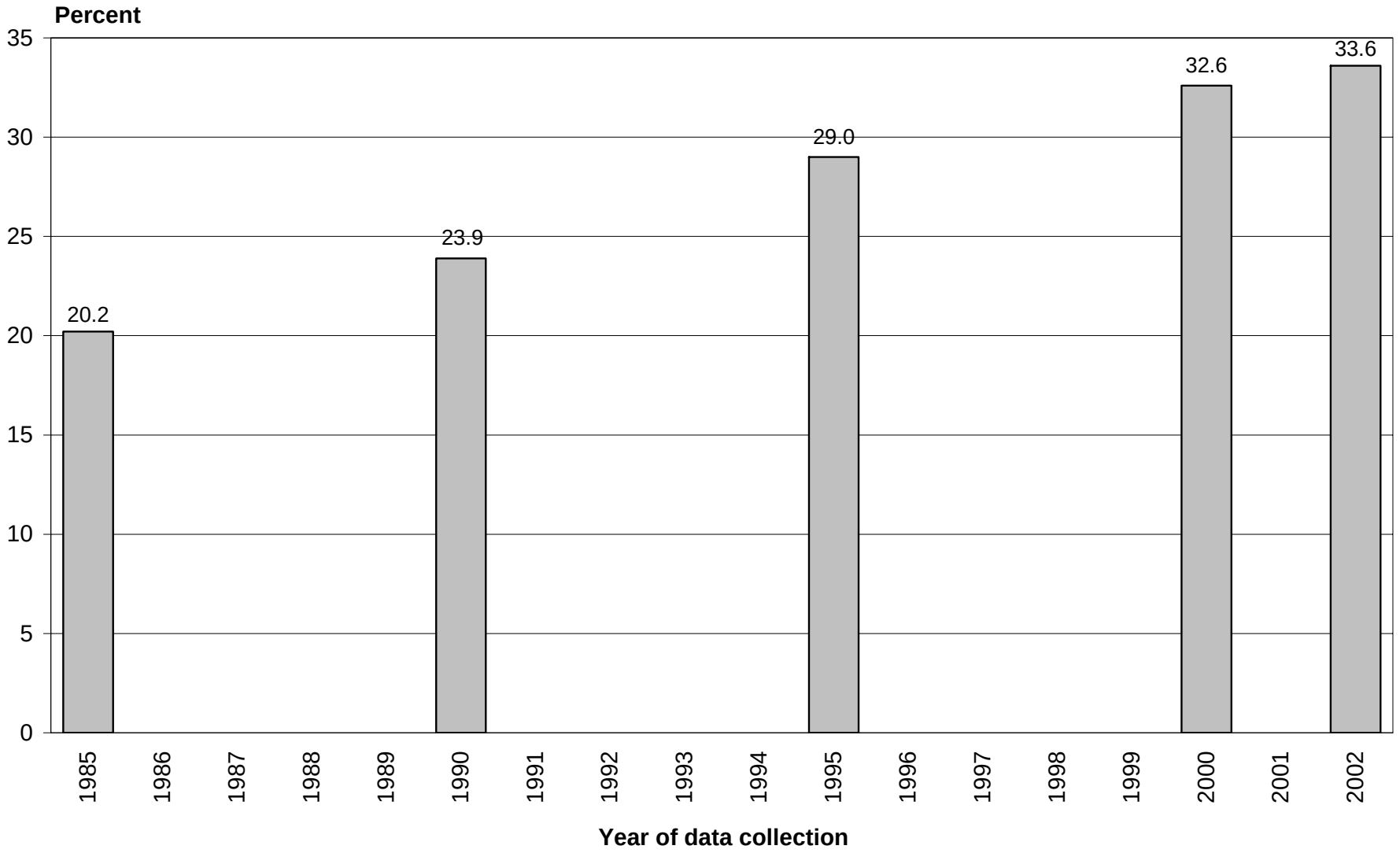
Source: OECD Human Resources for Health Care project.
Notes: Data for England relate to physicians in the National Health Service. Data for New Zealand refer to foreign-trained practising physicians.

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



Source: MCNZ

Figure 8: Females as a percentage of active medical practitioners



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

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, continuity, quality and cost of care.
- Wasteful use of scarce resources.
- Reduced safety for patients and doctors.
- Want a more informed and informative service.
- Convenient and affordable access.
- More care delivered in community settings.

Doctors' perceptions

- Poor structures and processes inhibit professional contribution.
- Pressures arise from existing doctor shortages.
- Concern about student loans and retention.
- Lack of clarity about roles and responsibilities.
- Perceived poor remuneration compared with international marketplace.
- The demands of bureaucracy and management.

Doctors' expectations

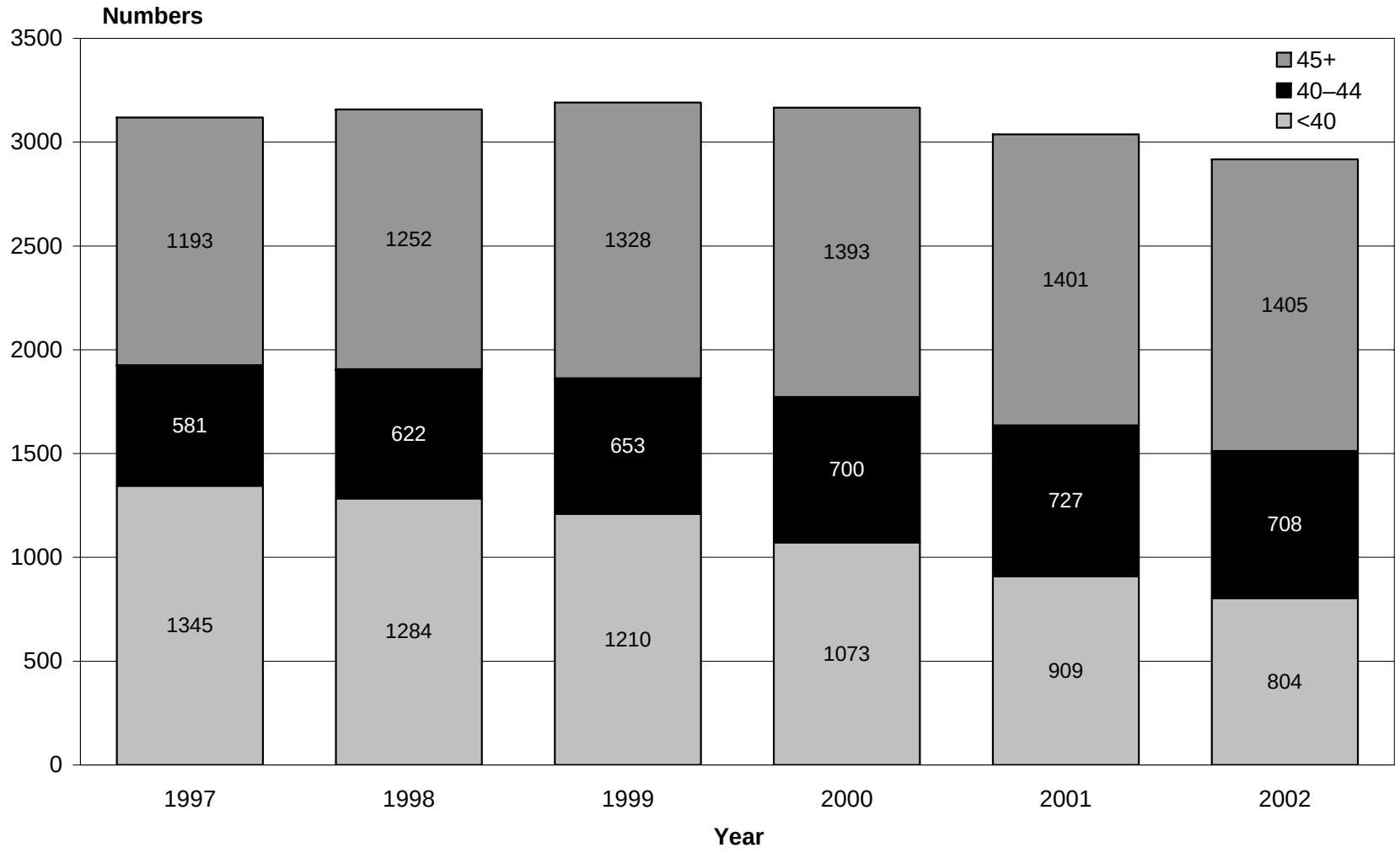
- Reasonable working hours and patterns of work.
- A clear, secure and flexible framework for career progression.

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 9: 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)

"I like this, Edwards. You've come up with more solutions than we have problems."

Health Workforce Advisory Committee (HWAC) and Medical Reference Group (MRG)

- A degraded structure of support.
- Poor communication and cooperation.
- Narrow, siloed thinking.
- Little trust in political, managerial and professional health leadership.
- Continuing problems in data collection and analysis
- Lack of integration of 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 & TEC

- Concentrate on building primary health workforce.
- Take a population health approach.
- Address health inequalities.
- Involve consumers, service providers and local communities.
- Complete an analysis of the current provision of education and clinical training.
- Improve the Ministry's workforce information.
- Complete a discussion paper on workforce responses to an ageing population.

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 and ready for work programmes for overseas doctors.

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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www.mcnz.org.nz
IAMRA website:
www.iamra.com