The Royal New Zealand
College of General Practitioners

2005 RNZCGP Membership Survey

General Practice in New Zealand

Part II

Future Workforce Intentions, Teamwork and Remuneration

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1. Executive summary

The Royal New Zealand College of General Practitioners (RNZCGP) seeks to improve the health of all New Zealanders through the promotion of high quality general practice care.

In 2005, the College surveyed its membership to obtain information on their current working arrangements, working conditions and future intentions. The completion of the 2005 survey was voluntary. The survey was sent to 3411 College members. The completed surveys were returned to the College and the data entered and quality assured by checking the accuracy of the data input process. The response rate was 60% (2057 members/participants) with a margin of error of ± 1.35% at the 95% Confidence Interval.

Interpreting future workforce intentions is difficult, but the findings suggest that the GP workforce is not only ageing but also responding to perceived stressors by seeking/planning to leave general practice.

Future workforce intentions

- Approximately 30% (623) of GPs intend to change their work arrangements in the next five years. Approximately half of these were self-employed general practitioners with more males intending to change than females.
- Of particular concern is that 56% of participants who intend to change their work arrangements are in the age cohort 31-50 years. This cohort comprises the core of a stable workforce.

Intended changes in work arrangements suggests

- 18% of those intending change will retire in the next five years with men twice as likely to retire than women.
- The least favoured was fulltime self-employed general practice (less than 4%).
- Women favour part time and locum work and men favour non-general practice work and working overseas.

Factors influencing work intentions

- Retirement is the single most mentioned factor likely to influence future work intentions.
- The care of children and other family members is second.
- Third is a perceived decline in the income potential of general practitioners in the current primary care environment.
- Other factors mentioned included lack of job satisfaction, bureaucratic compliance, maternity (taking time-off to start a family), and the desire to travel or emigrate.

Involvement with PHOs

- Approximately 70% of GPs are part of a PHO, yet over 90% of the population are enrolled in a PHO. The reason for this anomaly in the data is not clear.
- GPs and general practice are actively supporting the implementation of the governments Primary Health Care Strategy but many comment that the structure of Primary Health Organisations have increased bureaucracy, compliance and paperwork.

Access to other health practitioners

- Teamwork remains an integral part of general practice.
- The Primary Health Care Strategy emphasises the need for multi-disciplinary teams, but the models for multi-disciplinary teamwork in the Primary Health Organisation environment are yet to be fully developed. Infrastructural, employment models and contractual issues need to be addressed.

GP remuneration

- Fulltime self-employed GPs tend to have higher incomes. But these GPs work longer hours.[1] Ironically this is the least favoured future work arrangement.
- The average GP income of ($77 500 for 1.0 FTE or $93 000 for 1.2 FTE[2]) does not compare well with other vocationally registered specialists, particularly those who are part of the collective agreement (MECA) between DHBs and the Association of Salaried Medical Specialists. The median income of GPs is approximately $96000 compared to the median of $137500 as offered by MECA.
- This inequity between self-employed GPs and those in the MECA is highlighted further in the fact that self-employed GPs income has to include cover for study leave, holiday entitlement, personal and practice professional development activities, whereas salaried GPs have these paid for by their employer. However due to the lack of cover (locums) for self-employed GPs, many have to forgo time for study and holidays, making self-employment less attractive.

New Zealand expresses its number of GPs based on Full Time Equivalents (FTEs). If the decline in the number of self employed GPs (who work the longest hours), and the trend toward part time and flexible working arrangements (e.g. locums) continues, then New Zealand's FTE GP numbers would erode very quickly, leaving fewer GP hours to see more patients. This in turn would impact the changing GP workforce, causing burnout and still further retention issues.

New Zealand relies on the self-employed GP (currently 56%) to deliver primary care locally. The self-employed GP has invested in the infrastructure and human resources necessary to meet the needs of their local patient register. Declining interest in self-employment or the small business model will increase the risk that currently available primary care delivery infrastructure will become less viable and sustainable.

Recommendations

Analysis of the data in the College's 2005 Membership Survey indicates urgent constructive action is needed to address these issues:

1. Ensure national workforce planning addresses changes in the future working arrangements and the demographic profile of general practice to assist GPs provide quality patient care.

2. Examine and adjust infrastructural and contractual issues within current business models that currently inhibits development and functioning of multidisciplinary teamwork

[1] RNZCGP 2005 Survey Report I
[2] 1.2 FTEs is the average hours worked by GPs in the current workforce.
[3] Gross income refers to total income before tax. In the case of self-employed GPs, gross income is their income minus all business expenses before tax.

3. Reverse the trend that is making self-employed general practice the least attractive option by developing new business models that recognise and support the contribution of small business to the delivery of quality primary health care.

4. Commission a stocktake at PHO level that analyses current bureaucratic and compliance requirements for relevance and efficacy in the delivery of quality patient care.

The final report from the 2005 survey will look at the 'General practitioners working in Urban and Rural New Zealand'.

2. Introduction

This is the second report on the findings of the 2005 membership survey sent to all members of the College in April 2005. Approximately 93% of GPs in New Zealand are members of the College and the survey's response rate was 60% (2057 members/participants) with a margin of error of ± 1.35% at the 95% Confidence Interval.

The Royal New Zealand College of General Practitioners (RNZCGP) seeks to improve the health of all New Zealanders through the promotion of high quality general practice care. It delivers postgraduate education; professional development and quality programmes aimed at supporting and strengthening general practice as well as providing support and advocacy for general practitioners[4] (GPs).

Whereas the first report looked at GP demographics, work arrangements and working hours this report focuses on GP future workforce intentions, intended changes to working arrangements and factors likely to influence future workforce intentions. The report also looks at GPs perceptions of their involvement with:

- PHOs,
- Other health professionals in primary care, and
- GP income.

As indicated, the data represents a snapshot of GP's future workforce intentions during the development of Primary Health Organisations (April to August 2005). This report overlays the views of GPs onto the workforce demographics data outlined in the first report to highlight the issues facing GPs as they adapt to the implementation of the Government's Primary Health Care Strategy. Future surveys will provide data for trend analysis.

Previous membership surveys were completed in 2000 and 2003. The 2003 survey had some similar questions and was used for comparisons where appropriate.

Initially, the College had planned four reports, but after careful consideration the contents of report two and three have been consolidated into this report. It is planned that the third and final report will analyse the data to provide information about general practice in urban and in rural New Zealand.

[4] GPs here refer to those who are vocationally registered (VR) and also those who are under general registration until College Fellowship/VR is achieved.

3. Future Work Intentions of GPs

In 2005, 27% (564) of participants said that they intend to change their work arrangements in the next 5 years. Approximately 3% (59) of participants said that they were *unsure* as to their future work intentions, however some of them went further and indicated their choice for change of work arrangements, should the opportunity arise.

For the purpose of clarity, all those who indicated that they were *unsure* have been combined with those who clearly indicated that they intend to change. Hence, approximately 30% (623) of the participants intend to change their work arrangements in the next 5 years.

Of those GPs, approximately 47% of them are currently self-employed, 14% are in salaried positions, and 18% are locums (Table 1). Also, some participants selected more than one option from the work arrangements listed; so 623 participants provided 723 responses.

Table 1: Current work status of those intending to Change

Work Status	Number	%
Locum	128	17.7
P.T. Sal GP	52	7.2
F.T. Sal GP	47	6.5
P.T. S.E. GP	111	15.4
F.T. S.E. GP	228	31.5
Sub-speciality	21	2.9
Non GP Med work	50	6.9
Non-Med work	11	1.5
Work Overseas	17	2.4
Unpaid work	6	0.8
Retired	4	0.6
Other	48	6.6
Total	723	100

More male GPs (379; 32% of the total male participants) intend to change their work arrangements in the next 5 years, compared to 244 (28%) of the total female participants. Furthermore, GPs in the age cohort of 31-50 make up the largest group (56%) intending to change work arrangements, compared to 41% of GPs in the age cohort of 51-70. In other words, more of the younger GPs intend to change their work arrangements than do older GPs. This ought to be of concern given that GPs in this age cohort will be required to deliver quality primary health care to all New Zealanders, including the increasingly ageing population.

4. Intended Change in Work Arrangements

If participants intended to change their work arrangements they were asked what they planned to do. Some participants selected more than one option from the work arrangements listed; so 623 participants provided 692 responses.

Retirement from general practice (18%) was the single most intended change chosen. Male GPs outnumber females approximately 2:1 among those intending to retire. Table 2 summarises the findings.

From all forms of paid employment, full-time self-employment in general practice is the least favoured change. Only 3.9% of those intending to change their work arrangements plan to go into fulltime self-employed general practice.

Table 2: Intended change in work arrangements

Work Status	Number	2005 %	2003%	Male (2005)	Female (2005)
Locum	85	12.3	8.2	10.8	14.6
P.T. Sal GP	49	7.1	4.9	5.3	9.9
F.T. Sal GP	26	3.8	3.7	3.8	3.6
P.T. S.E. GP	82	11.8	13.8	12.2	11.3
F.T. S.E. GP	27	3.9	27.2	3.1	5
Sub-speciality	43	6.2	0.7	6	6.6
Non GP Med work	74	10.7	1.5	11	10.2
Non-Med work	39	5.6	1.1	5.7	5.5
Work Overseas	71	10.3	1.5	10.8	9.5
Unpaid work	18	2.6	-	2.6	2.6
Retire	124	17.9	7.5	22	11.7
Other	54	7.8	29.9*	6.7	9.5
Total	**692**	**100**	**100**	**100**	**100**

* This percentage includes a combination of employment options from the list above.

Participants also indicated an increased desire to work as locums, in salaried positions, in sub-specialities, in non-general practice medical work and non-medical work, and to work overseas. Most of these work arrangement choices come at the cost of self-employed general practice opportunities (Table 2).

More female GPs would prefer to change to locum and part-time positions, compared to male GPs who would prefer to do non-general practice medical work and have an opportunity to work overseas (Table 2).

Analysing the 'intended change of work arrangements by age' (Table 3) suggests that very few of the age cohorts really want to be in fulltime general practice, whether it is salaried or self-employed. There is a preference for locum work, part-time general practice, sub-specialities, non-general practice medical work, and non-medical work among the 25-45 age cohorts.

One reason for this could be the desire for more balance between work and life. As the first report demonstrated many GPs who work part-time are in fact working between 35-37 hours per week, almost 0.9 FTEs. Achieving work/life balance could also be a reason for not wanting to be a self-employed GP as

fulltime self-employed GPs spend the most number of hours per week (approx. 59hrs/wk: 1.5 FTEs) in general practice.

The first report also highlighted the increase of hours GPs spend per week in general practice; from 44hrs/wk to 48hrs/wk between 2003 and 2005. This was not a result of increased patient consultation, but due to an increase in paperwork to meet compliance and bureaucratic requirements. The data from the 2005 survey suggests increased compliance in general practice may limit recruitment of new graduates and adversely impact retention of GPs already in practice, as many existing GPs have mentioned having had enough of compliance, paperwork and bureaucratic issues.

Table 3: Intended Change of work arrangements by Age

	A*	B*	C*	D*	E*	F*	G*	H*	I*	J*	K*	L*	%	No.	T. Res
25-30	25	12.5	0	12.5	0	12.5	12.5	0	12.5	0	0	12.5	**100**	**5**	**8**
31-35	7.7	23	5.8	17.3	7.7	5.8	9.6	1.9	7.7	5.8	0	7.7	**100**	**43**	**52**
36-40	15.1	5.5	6.8	8.2	4.1	4.1	19.2	6.8	12.3	1.4	2.7	13.7	**100**	**69**	**73**
41-45	10.8	8.5	3.1	10	5.4	11.5	17.7	11.5	7.7	2.3	4.6	6.9	**100**	**111**	**130**
46-50	14.1	7.8	5.5	12.5	6.3	2.3	8.6	7	15.6	2.3	9.4	8.6	**100**	**123**	**128**
51-55	13.8	5.2	4.3	12.9	3.4	8.6	9.5	4.3	12.9	4.3	12.9	7.8	**100**	**96**	**116**
56-60	15.2	2.2	1.1	9.8	1.1	8.7	4.3	3.3	13	2.2	31.5	7.6	**100**	**77**	**92**
61-65	9.4	3.8	1.9	20.8	0	0	3.8	1.9	0	0	52.8	5.6	**100**	**56**	**53**
66-70	4.8	4.8	0	0	0	0	4.8	0	0	4.8	81	0	**100**	**24**	**21**
70+	0	0	0	11.8	0	0	11.8	0	0	0	76.5	0	**100**	**17**	**17**
UNK	50	0	0	0	0	0	0	0	0	0	50	0	**100**	**2**	**2**
Total														**623**	**692**

*__A__= Locum; __B__=Part-time salaried GP; __C__=Fulltime salaried GP; __D__= Part-time self-employed GP; __E__=Fulltime self-employed GP; __F__=Sub-specialised in G.P.; __G__=Non general practice medical work; __H__=Non-medical work; __I__=Working overseas; __J__=Unpaid work; __K__=retired; __L__=Other- eg. Academia, administration,

As might be expected, many GPs above 50 years of age are contemplating retirement. Some GPs in this same cohort (over 50) would also prefer to work as locums or in part-time positions. The percentage of GPs who would like to work outside New Zealand, especially GPs between 46-50, has increased. It is unclear from the data whether moves to work overseas would be permanent.

5. Factors likely to influence future work intentions

The survey asked members *'what factors may influence your future work intentions?*' This question sought to identify the factors/reasons/issues that may influence GPs decision regarding their future in general practice.

The level of response to this question was surprising with as many as 55% (1138) of participants having various factors/reasons/issues that are likely to influence their future work intentions. While some of the factors/reasons/issues stated are positive and relate to lifestyle preferences, others relate to stressors in the workplace. A total of 1138 participants gave 1450 responses. These responses have been summarised in Table 4.

Retirement (19%) is again the single most mentioned factor likely to influence future work intentions, particularly among men. From Table 3 above, some younger GPs (36-50) are already contemplating retirement from general practice. A majority have mentioned '*having had enough of the general practice environment in New Zealand*'.

Table 4: Factors that may influence future work intentions

Factors/Reasons/Issues			No.	%
Retirement			279	19.2
Family (including care of children & family members)			218	15
Declining income in general practice			140	9.7
Personal health (including anticipated illness due to current conditions)			129	8.9
Lack of work satisfaction			107	7.4
Regulation of GPs (including the burden of bureaucracy)			101	7
Maternity			97	6.7
Emigration/Travel/Moving overseas (including following spouses when they change employment)			94	6.5
Others:	**No.**	**%**	285	19.6
Lack of holidays, personal choice, other job offers, perception of general practice, PHO developments, lack of desire to remain a GP, boredom, other income streams, on-call commitments, frustration, missionary work, large student debt, death, research work and flash of inspiration.	*112*	*7.7*		
Sub-specialise (including changing to other vocations)	*46*	*3.2*		
Politics of government (including politics in health)	*43*	*3*		
Reduce hours in general practice	*19*	*1.3*		
Lifestyle choices	*15*	*1*		
Lack of locums and drs. to cover practice	*15*	*1*		
Change structure of practice to make it viable	*13*	*0.9*		
Overload of Paperwork (related to regulation of GPs)	*12*	*0.8*		
Winning Lotto	*10*	*0.7*		
Total Others	***285***	***19.6***		
Total (Total of 1138 participants)			**1450**	**100**

A perceived decline in the income potential of general practitioners (10%) is another factor likely to influence GPs' future work intentions. Many GPs have said that the income they are receiving currently is not worth the effort they put into providing primary health care and running a business. As a result some GPs are opting for salaried positions with DHBs and PHOs and are beginning to be remunerated at rates comparable to other medical specialists. This trend may contribute further to a decline in the attractiveness of self-employed general practice. Interestingly, more male GPs mentioned declining income as a factor likely to influence future work intentions.

Other factors likely to affect workforce numbers are the lack of work satisfaction (7%) and GP wellbeing (personal health- 9%). Many GPs said they are overworked, have had a 'guts full', are stressed, bored, are wasting their skills with compliance issues, and are overburdened with bureaucracy and paperwork. Similarly, many GPs have specifically mentioned that the regulation of general practice and the bureaucratic burden (7%) are major issues facing the current GP workforce. In the first report, the College recommended that an audit be done of the compliance costs and bureaucratic requirements to ascertain whether everything the government is demanding of GPs is necessary. This exercise will ensure that GPs are heard and their concerns are appropriately addressed. This may also help boost GP morale, attract graduates into general practice, and retain existing GPs.

Family needs (15%) and maternity (7%) are other factors likely to influence future work intentions. While these are positive reasons for wanting change, the overall impact on the workforce is still critical. Policy makers need to take into account such factors when planning a workforce. Also more female GPs mentioned family and maternity as factors likely to influence future work intentions.

Many participants (6.5%) also intend to travel/emigrate overseas either to support their spouses or to work. Some GPs have cited some of the reasons above like lack of work satisfaction as reasons for wanting to go overseas. This is likely to have a negative impact on workforce numbers.

A significant percentage of GPs (20%) gave various reasons that will impact their future work intentions such as the general practice environment (8%), the desire to sub-specialise (3%), politics of government (3%), and many others like reduce hours, lifestyle choices, and winning lotto (5%).

Table 5: Factors that may influence future work intentions by Age

Age	No.	Resp.	%	Factors/Reasons/Issues
25-30	16	26	1.8	Family, maternity, declining income, other issues (Table 4)
31-35	86	118	8	Family, maternity, declining income, other issues (Table 4)
36-40	150	198	13.7	Family, maternity, other issues (Table 4)
41-45	216	278	19.2	Family, emigration, regulation of GPs, lack of work satisfaction, personal health, declining income, other issues (Table 4)
46-50	212	265	18.3	Family, emigration, regulation of GPs, lack of work satisfaction, personal health, declining income, retirement, other issues (Table 4)
51-55	191	249	17.2	Family, regulation of GPs, personal health, retirement, other issues (Table 4)
56-60	130	154	10.6	Family, regulation of GPs, personal health, retirement, other issues (Table 4)
61-65	73	86	6	Personal health, declining income, retirement, other issues (Table 4)
66-70	33	36	2.5	Lack of work satisfaction, personal health, retirement, other issues (Table 4)
70+	23	28	1.9	Regulation of GPs, Lack of work satisfaction, personal health, retirement, other issues (Table 4)
Unk	8	12	0.8	All issues mentioned above. (Table 4)
	1138	**1450**	**100**	

The majority of GPs (69%) with factors/reasons/issues that are likely to influence future work intentions are in the age cohort of 36-55 (Table 5). Even if a small fraction of the GPs (approximately 10%), who have a *'reason to change',* decided to leave general practice immediately, the workforce would suffer a loss of over a 100 GPs; which will take two intakes of fulltime study (2 years) to replenish. This however will not take into account those leaving general practice in the 2-year period needed to replenish the original shortfall.

6. Changing environment: GPs perceptions

6.1 Involvement with PHOs

Between April and August 2005, 1433 (69.7%) of survey participants said that they were part of a PHO. The majority were either in fulltime (45.6%) or part-time self-employed general practice (21.5%). Approximately 8.8% and 6.3% respectively were in fulltime and part-time salaried general practice. It is known that a large percentage of the population was enrolled in PHOs during this period, so this figure appears to under report GP involvement. There are several possible explanations.

- The survey did not ask whether the participant would be joining a PHO only if they were members of PHO? Those who were negotiating to join local PHOs would not be identified by the question.
- Some types of work arrangements may not bring GPs into direct contact with their PHO. For example:
    - Subcontracting GPs working for a practice owner.
    - Locums.
    - Salaried GPs employed on a contract.

It is intended that future surveys clarify how GPs see themselves in relation to Primary Health Organisations (PHOs).

Of those who said they did not belong to a PHO, 24% were locums and approximately 31% were self-employed GPs. The remainder were salaried, overseas, non GP-work, etc.

In 2003, 56% of the GPs surveyed had not joined a PHO. However, the 2003 survey only investigated a representative sample, approximately 18% (500) of GPs with a response rate of 54%. Some reasons given for not wanting to join a PHO in 2003 included lack of awareness about the nature of contracts being offered, some GPs could see only limited benefits from joining, and some disagreed with the principle of PHOs.

It is clear however, that GPs (and especially self-employed GPs) are participating in the implementation of PHOs but that there still are challenges to be faced. While in the 2005 survey, GPs were not asked whether they wished to join a PHO, many commented that the PHO structure had increased the burden of bureaucracy, compliance costs, and paperwork. These observations are consistent with PHO funding policy, whereby future funding is often withheld until all the information requirements of the system are fulfilled. These bureaucratic requirements are driving many current and potential GPs away from general practice. As recommended in the first report, there needs to be an in-depth audit of the bureaucratic and compliance cost issues to ensure that GPs are not being overburdened by unnecessary paperwork.

The first report found that the majority of GPs (56%) are still self-employed and operate as businesses that need to remain profitable to sustain future service provisions. This business model developed over time within a policy and regulatory environment that was largely supportive. This model was seen

as being compatible with the need to provide quality family medicine in majority of the settings and allow for the independence of GPs to achieve this goal. However, self-employment and the business model appear to be declining in popularity among new and some existing GPs entering the workforce.

6.2 Access to other health professionals

The survey asked GPs to indicate the average number of professionals available to a practice at any given time on a fulltime basis (Fulltime Equivalents (FTEs)). Participants were also able to specify categories of professionals who were not listed if they wished to. Table 3 gives a breakdown of the findings. It should be noted that due to the nature of the question asked in the survey, the interpretation of the data creates a certain amount of confusion and contradictions. The question on teamwork will be revised for future surveys. There was little difference when comparing the findings of the 2003 survey to those presented below (2005 survey).

Table 6: General Practice Teams

GENERAL PRACTICE TEAMS	(FTE)	Numbers
Solo GP	1.8	351
Partner GP	3.2	1041
Associate GP	2.4	867
MLT (Medical Lab. Technician)	1.5	131
Pharmacist	1.7	131
Practice Nurse	2.8	1435
Practice Manager	1	1013
Receptionist	2.4	1379
Radiographers	1.3	91
Others: (midwives; social workers, etc)	1.9	175

Solo GPs

Three hundred and fifty one (351; 16%) of the participants said that they worked as solo GPs averaging 1.8 FTEs or approximately 72hrs. The findings suggest that some solo GPs are now working with other health professionals and are sharing practice resources to maximise efficiency and minimise financial risk.

Solo GPs have been saying for a long time that they are working very long hours due to increased demand for their services and a lack of availability of part-time/locum GPs to help cover some of the workload when required. Few solo GPs mentioned having access to any other allied health professionals such as medical laboratory technicians (MLT), radiographers, and 'other' health workers.

Partners and associates

The majority of GPs are in partnerships (1041;46%) with an average of 3.2 FTE GPs per 'partnered' practice. Most 'partners' (66%) are in part-time or fulltime self-employed general practice. It should be noted that the actual hours worked by GPs in partnered practices is similar to those worked by solo GPs based on the overall hours worked by self-employed GPs. A significant

number of participants (867:38%) mentioned being associate GPs; only 7.3% (63) are associated with solo GPs, 44.3% (384) are associated with partnered practices, and 48.4% (420) are not associated with solo or partnered GPs.

Practice nurses
Practice nurses play an integral role in general practice. The majority of practice nurses (64.2%) work with GPs who are self-employed in either fulltime or part-time positions. On average, general practices have access to 2.4 FTE practice nurses.

Practice Managers
Approximately 50% of general practices have a practice manager. GPs who are part-time or fulltime self-employed (62%) and GPs in fulltime and part-time salaried positions (18.7%) mentioned having a practice manager.

Receptionists
Sixty seven percent (67%: 1379) of the participants have receptionists in their practices with an average of 2.4 FTE, i.e. those practices that have receptionists average about 2.5 fulltime receptionists each.

'Other' Team members
Approximately 9% of GPs have access to an assortment of health workers and other professionals to assist with patient care. They include radiographers, med. lab. technicians, pharmacists, counsellors, midwives, physiotherapists, phlebotomists, psychologists, psychiatrist, social workers, community health workers, mental health workers, osteopaths, dentists, dieticians, accountants, typists, administration staff, drivers, and cleaners. While some are directly involved with patient care, others assist in providing a favourable environment for GPs to work in.

Finally, given that multidisciplinary teamwork in the PHO environment is still being developed, it will be awhile before its desired capacity to deliver primary health care is fully realised. Most GPs are currently preoccupied with regulatory and funding issues in the PHO environment, and once these issues are satisfactorily sorted then more attention can be given to the role(s) of multidisciplinary teams. There is a range of issues still to be addressed about who will constitute these teams and how they will function effectively.

6.3 GP Remuneration

GP Training and Continuing Medical Education
Like other health professionals, GPs need many years of training before they are deemed capable of practicing on their own. For GPs, there is approximately six years of postgraduate training. This level of training is mandatory for doctors but is required by few other health professionals. In addition, GPs are required to continually refresh their previous education and acquire new knowledge and skills to provide patients with the best possible

[5] Take-home pay refers to gross income that is 'income before tax'.
[6] Gross income refers to total income before tax. In the case of self-employed GPs, gross income is their income minus all business expenses.

care. The level of income for many GPs does not match their educational requirements and commitment to continued medical education, which is often done in the GPs own time.

GP Income by work status

Participants were asked to identify their gross income from general practice from a series of bands. Self-employed GPs were asked to indicate their annual income net of expenses.

Analysing income level distribution by work status (Table 7) reveals that full-time self-employed GPs tend to have higher incomes (Self-employed GPs stated their net income i.e. income after deducting all practice related expenses but before tax). Being self-employed carries a greater financial risk. Interestingly, a small but significant number of part-time GPs have high gross and net income levels (depending on whether they are salaried or self employed). From an income perspective, it is still desirable to be a self-employed GP because their net income is often greater than many GPs who are salaried (gross income). However, this may not be the case if the hourly pay rate were investigated given the additional demands on time associated with running a business. The majority of GPs are motivated by the clinical challenges of primary health care together with flexible working arrangements that allow for high levels of autonomy.

Analysing income distribution by work status (Table 7) reveals that:

- Majority of locums (74%) earn less than $90 000 p.a. Approximately 5% of locums earn more than $130 000 p.a. Locums on average work 37 hrs/wk (0.93 Full Time Equivalent (FTEs)).

Table 7: Income distribution by Work Status

Income	A*	B*	C*	D*	E*	F*	G*	H*	I*	J*	K*	L*
Less than $30000	22.2	17.6	0.5	16.1	0.1	12.5	26.7	21.7	5.9	33.3	33.3	20.2
$30000-50000	19.9	24.2	1	18.8	1.3	7.5	12.2	4.4	2.9	11.1	13.3	7.7
$50000-70000	15.1	22.9	5.5	14.7	6.9	7.5	9.2	8.7	11.8	11.1	0	14.4
$70000-90000	16.4	17.6	17	14.7	13.5	7.5	6.9	8.7	14.7	11.1	6.7	9.6
$90000-110000	8.7	5.9	28	13	19	12.5	7.6	13	8.8	0	0	8.7
$110000-130000	7.1	3.3	25.5	5	16.9	10	7.6	4.4	2.9	11.1	0	8.7
$130000-150000	3.5	1.3	9.5	3.6	12.2	10	2.3	4.4	0	0	0	4.8
$150000+	1.6	3.9	11	7.2	25	25	9.2	13	26.5	0	6.7	9.6
Unknown	5.5	3.3	2	7	5.1	7.5	18.3	21.7	26.5	22.2	40	16.3

*__A__= Locum; __B__=Part-time salaried GP; __C__=Fulltime salaried GP; __D__= Part-time self-employed GP; __E__=Fulltime self-employed GP; __F__=Sub-specialised in G.P.; __G__=Non general practice medical work; __H__=Non-medical work; __I__=Working overseas; __J__=Unpaid work; __K__=retired; __L__=Other- eg. Academia.

Note: The figures in the table tally to a 100% by work status as opposed to income range categories.

- Majority of part-time GPs (salaried- 82%; self-employed- 64%) earn less than $90 000 p.a. Also in these two work categories, more self-employed GPs (10.8%) make more than $130 000 p.a. compared to those in salaried positions (5.2%).

- Majority of fulltime GPs (salaried- 74%; self-employed- 73%) earn more than $90 000 p.a. Fulltime salaried GPs work 55hrs/wk or 1.4 FTEs and fulltime self-employed GPs work 59hrs/wk or 1.5 FTEs. However, more fulltime self-employed GPs (37%) earn more than $130 000 p.a. compared to only 20.5 % of salaried GPs. This disparity may indicate that self-employment is financially better than a salaried position, or that salaried GPs are not receiving the level of income as stipulated by the DHBs and the Association of Salaried Medical Specialists-MECA Agreement (ASMS, 2005).
- Majority of the GPs working in sub-specialities (57.5%) earn more than $90 000 p.a. with 35% of them earning more than $130 000 p.a. This compares favourably with self-employed GPs.
- Majority of the GPs working in non-general practice medical work (55%) earn less than $90 000 p.a. with 27% of them earning less than $30 000 p.a.
- Majority of the GPs working in non-medical work (56%) earn less than $110 000 p.a. with 22% of them earning less than $30 000 p.a.
- More than a quarter of the GPs working overseas (26.5%) earn more than $150 000 p.a.
- Majority of the GPs working in 'other' occupations such as management and academia (52%) earn less than $90 000 p.a. with 20.2% of them earning less than $30 000 p.a. Approximately 10% of them earn more than $150 000 p.a.

Overall, GPs working overseas make up the largest portion of those earning over $150 000, and are the smallest portion of those earning less than $30 000 when compared to other fulltime GPs including locums, GPs in sub-specialities, non- general practice work and non-medical work.

GP remuneration in comparison with other medical specialists

The average GP income of ($77 500 for 1 FTE or $93 000 for 1.2 FTE[7]) does not compare well with other vocationally registered specialists, particularly those who are part of the collective agreement (MECA) between DHBs and the Association of Salaried Medical Specialists. The median income of GPs is approximately $96000 compared to the median of $137500 as offered by MECA. The entry-level income in MECA is $113 500 for medical specialists[8], and $82 500 for medical officers (ASMS, 2005).

Furthermore, the GP average income of $93 000 is Level 4 of the Medical Officers[9] salary range under the same agreement, and it is also $10 500 less than the median income of medical officers ($103 500) paid under the MECA. This agreement also provides medical specialists and officers with time off for

[7] 1.2 FTEs is the average hours worked by GPs in the current workforce.

[8] 'Medical Specialist' means any medical practitioner who is vocationally registered under the Medical Practitioners Act 1995 in one of the approved branches of medicine and who is employed in either that branch of medicine or in a similar capacity with minimal oversight (ASMS- MECA, 2003-2006).

[9] 'Medical Officer' means any medical practitioner who is registered under the Medical Practitioners ACT 1995 and who falls within the coverage clause of this Agreement and who is not a medical specialist (ASMS- MECA, 2003-2006).

holidays, study leave, and special benefits like reimbursement of membership fees for belonging to their professional organisations.

As noted above GPs earn less than other specialist doctors within the health system. Having said that the Association of Salaried Medical Specialists (ASMS) has developed a payment and expected working conditions schedule (MECA) that is being applied to some vocationally registered GPs working in the PHO/DHB environment. This has raised the income level and improved the working conditions of some GPs. However, more research is needed to determine whether there is consistency in its application across all the DHBs.

7. Summary of Key Findings

The findings of the College membership survey are outlined below.

Workforce intentions

- 30% (623) of the participants intend to change their work arrangements in the next 5 years.
- 47% of them are currently self-employed.
- More male GPs (379; 32% of the total male participants) intend to change their work arrangements in the next 5 years, compared to 244 (28%) of the total female participants.
- GPs in the age cohort of 31-50 make up the largest group (56%) intending to change work arrangements, compared to 41% of GPs in the age cohort of 51-70. This ought to be of concern given that GPs in this age cohort (31-50) will be required to deliver quality primary health care to all New Zealanders, including the increasingly ageing population.

Intended change in work arrangements

- Retirement from general practice was the single most intended change chosen. Reflecting the demographics of general practice outlined in the first report male GPs are twice as likely to be considering retirement as female GPs.
- Only 3.9% of those intending to change their work arrangements plan to go into fulltime self-employed general practice.
- More female GPs would prefer to change to locum and part-time positions, compared to male GPs who would prefer to do non-general practice medical work and have an opportunity to work overseas.
- Very few of the age cohorts really want to be in fulltime general practice, whether it is salaried or self-employed. There is a preference for locum work, part-time general practice, sub-specialities, non-general practice medical work, and non-medical work among the 25-45 age cohorts.

Factors likely to influence future workforce intentions

- Retirement is again the single most factor/reason that is likely to influence future work intentions, with family needs being second.
- A perceived decline in the remuneration for GPs is likely to influence GPs' future work intentions.
- Many GPs have said they are overworked, have had a 'guts full', are stressed, bored, are wasting their skilling with compliance issues, and are overburdened with bureaucracy and paperwork.
- Approximately 6% indicated that opportunities overseas could influence their future workforce intentions.
- Most GPs with factors/reasons/issues that are likely to influence future work intentions are in the age cohort of 36-55. Even if a small fraction of these (approximately 10%) decided to leave general practice immediately, the workforce would suffer a loss of over a 100 GPs; which will take two intakes (2 years) to replenish.

Involvement with PHOs

- Approximately 70% of GPs are part of a PHO, yet over 90% of the population are enrolled in a PHO. The reason for this anomaly in the data is not clear.
- GPs are participating in the implementation of PHOs but there are still challenges to be faced.
- While the 2003 membership survey found many GPs unwilling to join a PHO due to a range of factors, the 2005 survey finds that GPs have moved quickly to contribute to the implementation of the Primary Health Care Strategy.
- The majority of the participants who belonged to PHOs are either in fulltime self-employed general practice (45.6%), part-time self-employed general practice (21.5%), and fulltime and part-time salaried general practice (8.8% and 6.3% respectively).
- Many participants commented that the PHO structure had increased the burden of bureaucracy, compliance costs, and paperwork. These observations are consistent with PHO funding policies, whereby future funding is often withheld until all the information requirements of the system are fulfilled. These bureaucratic requirements are driving many current and potential GPs away from general practice.

Access to other health professionals

- Teams and teamwork is integral to the success of the Primary Health Care Strategy (2001). The aim of teamwork is to improve the quality of patient care as opposed to dealing with workforce shortages.
- Under the PHO system, GPs are encouraged to broaden their teams to provide more holistic health coverage through their practices. Public health initiatives, like health promotion and smoking cessation, are also being integrated into general practice work.
- General practice team currently consists of:
    - 351 Solo GPs working 1.8 FTEs (72 hrs/wk)
    - 1041 GPs in partnerships working 3.2 FTEs
    - 867 Associate GPs working 2.4 FTEs
    - 131 MLTs working 1.5 FTEs
    - 131 Pharmacists working 1.7 FTEs
    - 1435 Practice Nurses working 2.8 FTEs
    - 1013 Practice Managers working 1 FTE
    - 1379 Receptionists working 2.4 FTEs
    - 91 Radiographers working 1.3 FTEs
    - 175 'Other' Health workers such as midwives, social workers, etc working 1.9 FTEs.
- The survey finds that teamwork (between GPs, nurses, other health professionals) is well established in general practice even among solo GPs. However, while many GPs are now involved with PHOs, the findings suggest that general practice teams remains largely unchanged from the pre-PHO general practice. This suggests that fundamental infrastructure issues remain that are discouraging developments that emphasise multi-disciplinary approaches to services and decision-making.

- Most 'partners' (66%) are in part-time or fulltime self-employed general practice.

GP remuneration

- Analysing income level distribution by work status suggests that full-time self-employed GPs tend to have higher incomes. However, being self-employed carries greater financial risk and if the hourly pay rate were investigated given the demands associated with running a business then it is possible that this impression may be incorrect. More research is needed to further investigate this.
- The mean gross income for general practitioners is approximately $93 000 p.a. This GP income average is approximately $45 000 less then the median salary of Medical Specialists as specified in the collective agreement between the DHBs and the Association of Salaried Medical Specialists-MECA Agreement (ASMS, 2005).
- The GP average income of $93 000 is Level 4 of the Medical Officers salary range under the same agreement, and it is also $10 500 less than the median income of medical officers paid under the MECA agreement.
- This Agreement also provides medical specialists and officers with better working conditions such as time off for holidays, study leave, and special benefits like reimbursement of membership fees for belonging to their professional organisations.
- The mean gross income for female GPs' is about $74 000, compared to the male GPs' mean gross income of about $109 000. This disparity is likely to be a result of the fact that many female GPs are opting for locum or part-time employment.
- The majority of GPs working in sub-specialities earn rates that compare favourably with self-employed GPs.
- Overall, GPs working overseas make up the largest portion of those earning over $150 000.
- GPs who are 70+ comprise the largest group earning less than $30000
- GPs between 46-65 comprise the largest group earning $150000+
- GPs between 25-30 comprise the largest group earning between $70000-$90000, and also between $110000-$130000
- Female GPs outnumber their male counterparts by approximately 3:1 (414:185 GPs) in the lower income brackets, and conversely male GPs outnumber their female counterparts by as high as 4:1 (560: 135 GPs) in the higher income brackets.
- It is interesting to note that some female GPs are getting high incomes working as locums and part-timers, as opposed to many male GPs getting similar income working in fulltime positions. (*While male GPs outnumber female GPs in the higher income brackets, approximately 40% of all female GPs earning more than $130,000pa make their (high) income in part-time GP work or as locums or in non-general practice medical work, compared to approximately 20% male GPs doing same types of work)*.

7.1 Conclusion

This report is the second of a series based on data gathered by the College as part of its membership survey. This research needs to be looked at in the context of the changing New Zealand primary health care environment and against the background of multidisciplinary primary health care teams.

The general practice workforce in New Zealand is facing a time of reckoning. Survey trends reveal a stressed and diminishing GP workforce:

- it is ageing faster than it is being replenished;
- many GPs are considering changing their future working arrangement;
- it is heavily reliant on overseas trained doctors and
- GPs are increasingly frustrated by bureaucracy and compliance issues.

This shortage of GPs will be further affected by current GPs moving into other vocations or reducing their commitment to general practice. The survey indicates that self-employment among GPs is becoming less attractive and is on the decline. An increasing number of GPs are opting for salaried positions. However, this shift from a predominantly private business mix to a more public funded mix will create challenges of its own. Further research is planned to elicit what these challenges might be.

Constructive actions are needed now to address these issues:

5. Ensure national workforce planning addresses changes in the future working arrangements and the demographic profile of general practice to assist GPs provide quality patient care.

6. Examine and adjust infrastructural and contractual issues within current business models that currently inhibits development and functioning of multidisciplinary teamwork

7. Reverse the trend that is making self-employed general practice the least attractive option by developing new business models that recognise and support the contribution of small business to the delivery of quality primary health care.

8. Commission a stocktake at PHO level that analyses current bureaucratic and compliance requirements for relevance and efficacy in the delivery of quality patient care.

The final report from the 2005 survey will look at the 'General practitioners working in Urban and Rural New Zealand'.

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