The Royal New Zealand
College of General Practitioners

2008 RNZCGP Membership Survey

THE GENERAL PRACTITIONER WORKFORCE

Current Demographics

Emerging Trends

WORKFORCE SERIES 8

November 2009

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The College would like to thank all those members who participated in the 2008 Membership Survey. Your contribution is highly valued, and it will assist us in developing services to meet members' needs and advocating on your behalf.

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1. Executive Summary

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

This report presents the 2008 data based on gender and age cohorts. A major focus is on emerging trends as the College now has reasonable data from its previous membership surveys in 2000, 2003, 2005, 2006 and 2007.[1]

Summary of key findings of the 2008 survey

- A total of 961 male GPs (53%) and 838 female GPs (47%) participated in the survey.
- Seventy-four percent of GPs in the 25–35 age cohorts were females.
- GPs in the 36–45 age cohorts preferred self-employment and locum work.
- The 46–55 age cohorts had the highest percentage of GPs working in rural areas and those intending to change their work arrangements in the next five years.
- Seventy-five percent of GPs in the 56–65 age cohorts were males; worked the longest hours; and the majority intend to retire in the next five years.
- GPs in the 66–71+ age cohorts preferred locum work and self-employment; the majority will retire in the next five years.

Summary of trend data 2003–2008

- Since 2005, the number of female GPs participating in College membership surveys has increased. This reflects the increase in the number of female medical graduates joining general practice.
- The mean and median age of GPs continues to increase as the GP workforce ages.
- There were more GPs aged 46 years and over in 2008 than in 2005–2007.
- There were fewer GPs aged 35 years and under in 2008 than in 2005–2007.
- There was a significant decrease in the percentage of GPs aged 36–45 years in 2008 than in 2003–2007.
- More than half of all participants have been in general practice for more than 16 years.
- New Zealand Europeans and Europeans constitute the majority of GPs.
- Self-employed GPs may no longer be the majority in the GP workforce. Many self-employed GPs are choosing other work arrangements.
- The decline in self-employment has been accompanied by an increase in GPs doing locums, salaried work, sub-specialty, non–general practice medical work, non-medical work, unpaid work, academia, and other types of work.

[1] **NOTE:** For the purpose of the College's membership workforce survey reports, the term 'general practitioners (GPs)' refers to a doctor who is working in general practice.

- Since 2005, the number of GPs involved in non-medical work such as management positions within DHBs and PHOs has increased seven-fold, and unpaid work has increased 12-fold.
- GPs spent a greater percentage of their time consulting with patients in 2008 than they did in 2005.
- GPs are spending a lower percentage of their time on on-call duties (after-hours care).
- The average hours worked per week by GPs has decreased from 48 in 2005 to 42 in 2008; male GPs reduced their average hours from 55 in 2005 to 49 in 2008, while female GPs reduced their average hours from 39 in 2005 to 34 in 2008.
- Male GPs continue to work more hours than female GPs.
- GPs in the 46–65 age cohorts continue to spend over 1FTE per week in general practice.
- Nearly a fifth of GPs will retire within five years.
- Retirement, current working conditions, family considerations and personal health are factors likely to influence the future work intentions of GPs.
- Although there is an increase in the recruitment of medical graduates into general practice in 2008–09, it may not be enough to replace the GPs who are likely to retire in the near future.

Constructive action is still needed to address the following issues:

1. Ensure that New Zealand remains an attractive primary health care environment in order to retain New Zealand GPs and attract IMGs.
2. Ensure further research to examine trends towards GPs attaining a better work/life balance.
3. Ensure further research to examine trends towards GPs' choice of work such as self-employment, and the changes to the small business model.
4. Ensure efficient and effective strategic workforce planning by consolidating and standardising national workforce data to improve timeliness, accuracy and comparability.

2. Introduction

2.1 Background

The Royal New Zealand College of General Practitioners 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 (GPs).

Approximately 93% of GPs in New Zealand are members of the College. Seven percent of GPs, who are on the Medical Council of New Zealand's provisional register, are not members of the College. These GPs are often in New Zealand for short periods of time, however some are known to stay on for longer periods.

The College maintains databases of its members (Fellows, Members, and Associates and Affiliates[2]). In September 2008, there were 3773 members of the College. Of these, 2721 were Fellows and 1052 were involved in different stages of training to attain Fellowship and registration in the general practice vocational scope of practice. Some have retired but maintain College membership.

The 2008 report follows a new format that presents the data based on gender and age cohorts. The purpose was to streamline and simplify data presentation. A major focus of the new format is on emerging trends as the College now has reasonable timeline data from its membership. Previous membership surveys were completed in 2000, 2003, 2005, 2006, and 2007. The 2003, 2005, 2006, 2007 and 2008 surveys had similar questions; the 2006 mini-survey combined two questions from the 2003 and 2005 survey around current work status and hours worked. This report explores emerging trends, primarily comparing data from 2003, 2005, 2006 (where appropriate), 2007 and 2008 surveys.

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[2] **Fellow (FRNZCGP):** Fellowship of the College is attained by sitting the Primex exam, then completing the General Practice Education Programme Stage 2. Fellows have full voting rights and have the privilege of the floor at general meetings. They may also hold any office within the College. Fellows are entitled to use the designation FRNZCGP.

Member (MRNZCGP): The College awards Membership after successful completion of the Primex exam to those candidates who have also successfully completed the course requirements of the General Practice Education Programme Stage 1 of the College or an equivalent programme. A Member who is of good standing is entitled to the privilege of the floor at general meetings, may vote and may hold office except where the office requires that it be filled by a Fellow. Members are entitled to use the designation MRNZCGP.

Associate: Most Associates of the College are engaged in general practice, however, doctors who are practising within a College-recognised special interest area of primary care also have entitlement to Associate membership. Associates may take a full part in College affairs, except that they may not vote at the Annual General Meeting of the College.

Affiliate: Affiliate status may be granted to any individual who has special links with general practice and desires to become affiliated with the College. It may also be granted to organisations that have special links with general practice. Affiliates may not vote or hold office.

2.2. Study method

The 2008 membership survey was sent to 3477 members of the College in June 2008 as part of the annual subscriptions mail-out. The participation in the 2008 survey was voluntary. This survey was not sent to Life members and Primex Special candidates.[3]

The survey asked participants about their current work status, the hours worked, their future work intentions, their satisfaction with the College's activities, advocacy and communications, and their remuneration. The aims were to gather data about College members' current working patterns and construct a longitudinal view of work preferences and hours worked per week.

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 52% (1799 members/participants). The response rates in the 2007, 2006 and 2005 surveys were 52%, 49% and 60% (respectively).

Demographic data was extracted from the information provided on College subscription forms and linked to demographic data on all the participants from the College database.

[3] Life members are not required to pay annual subscriptions, hence they do not get the survey questionnaire attached to the annual subscription form. Also those people who are doing Primex Special are not yet fully registered members of the College and did not get the annual subscription form with the survey form attached to it.

3. Workforce Demographics

3.1 Participants

A total of 961 male GPs (53%) and 838 female GPs (47%) participated in the 2008 survey (Table 1). The College membership database was 56% for males and 44% for females. Since 2005, female membership has increased by 5%.

Table 1 shows the total number of College members at the time of the 2008 survey and the total number of survey respondents. Survey data in this report are presented unweighted.

Table 1: Survey response

	Males	Females	Total
AGE–GENDER	**N (%)**	**N (%)**	**N (%)**
2008 survey sent out to:	1947 (56)	1530 (44)	3477 (100)
2008 surveys completed from:	961 (53)	838 (47)	1799 (52)

The results of the 2008 survey are presented to highlight the most important findings based on gender and age. The key findings of each age cohort will be analysed by gender.

3.2 Key findings by gender and age

In 2008, the mean and median age of the GP workforce was 49. For male GPs, the mean and median age was 52; for female GPs it was 46. The majority of male GPs (54%) were aged 51 years and over compared to female GPs (57%) who were aged 50 years and under.

3.2.1 Age cohort: GPs aged 25–35 years

This age cohort comprised approximately 8% (139) of the survey participants. Seventy-four percent (103) were female GPs.

Table 2: Key findings of GPs in the 25–35 age cohorts

Age	Male (N=6)	Female (N=23)	(N=29) Summary
25–30	Male GPs in this age cohort: • Comprised less than 1% of all male GPs; • Preferred locum work (67%); • Preferred to work in urban areas; however a third work in rural areas.	Female GPs in this age cohort: • Comprised approx. 3% of all female GPs; • Preferred locum work (52%); • Overwhelmingly preferred to work in urban areas (91%).	GPs in this age cohort: • Comprised less than 2% of the survey participants; • Preferred locum work (49%); • Worked 39hrs/wk; • Spent 70% of this time consulting with patients, 14% on patient-related paperwork, and 4.6% on on-call duties; • Comprised 3% of those GPs who intend to change their work arrangements in the next five years; • Would prefer to engage in part-time self-employment (28%) and locum work (22%) in five-years' time; • Comprised 2% and 1.5% of all GPs who worked in rural and urban areas respectively; • Earned a median income of $100,000 and an average income of $95,560.
Age	**Male (N=30)**	**Female (N=80)**	**(N=110) Summary**
31–35	Male GPs in this age cohort: • Comprised 3% of all male GPs; • Preferred locum work (47%) and non-general practice medical work (33%); • Preferred to work in urban areas (90%).	Female GPs in this age cohort: • Comprised 10% of all female GPs; • Preferred locum work (48%), part-time self-employment (18%) and part-time salaried work (16%); • Overwhelmingly preferred to work in urban areas (91%).	GPs in this age cohort: • Comprised 6% of the survey participants; • Preferred locum work (34%), part-time self-employment (11%) and part-time salaried general practice work (9%); • Worked 33.5hrs/wk; • Spent 67% of this time consulting with patients, 14% on patient-related paperwork, and 4.5% on on-call duties; • Comprised 8% of those GPs who intend to change their work arrangements in the next five years; • Would prefer to engage in part-time (19%) and full-time self-employment (15%) and in other* types of employment (15%); • Comprised 3.5% and 6.5% of all GPs who worked in rural and urban areas respectively; • Earned a median income of $80,000 and an average income of $82,920.

* 'Other' work arrangements noted were: GPs doing studies, medicolegal work, after-hours care, police work (DSAC), sport team work, insurance consultancy, school clinics, various public health clinics, radio preparations, rest home work, prison MO, working for organisations caring for disabled and handicapped people, surgery, College work, research, farm work, GP liaison, ACC work, health advisory, and private business.

GPs in this age cohort, possibly due to a greater percentage of female GPs, preferred locum and part-time work. Female GPs in this age cohort often take time-off to start/raise a family. General practice allows them a greater degree of flexibility to raise a family and do general practice work.

3.2.2 Age cohort: GPs aged 36–45 years

This age cohort comprised 27.4% (493) of the survey participants. Sixty-two percent (305) were female GPs.

Table 3: Key findings of GPs in the 36–45 age cohorts

Age	Male (N=58)	Female (N=115)	(N=173) Summary
36–40	Male GPs in this age cohort: • Comprised 6% of all male GPs; • Preferred full-time self-employment (50%) and locum work (16%); • Preferred to work in urban areas (83%).	Female GPs in this age cohort: • Comprised 14% of all female GPs; • Preferred part-time self-employment (30%), locum work (23%); and part-time salaried positions (17%) • Overwhelmingly preferred to work in urban areas (96%).	GPs in this age cohort: • Comprised 9.6% of the survey participants; • Preferred full-time (20%) and part-time (18%) self-employment and locum work (16%); • Worked 33.4hrs/wk; • Spent 63.5% of this time consulting with patients, 15% on patient-related paperwork, and 7% on on-call duties; • Comprised 8% of those GPs who intend to change their work arrangements in the next five years; • Would prefer to engage in other* types of work (23%), locum work (16%) and part-time (14%) self-employment in five-years' time; • Comprised 5% and 10% of all GPs who worked in rural and urban areas respectively; • Earned a median income of $80,000 and an average income of $91,190.
Age	**Male (N=130)**	**Female (N=190)**	**(N=320) Summary**
41–45	Male GPs in this age cohort: • Comprised 13.5% of all male GPs; • Preferred full-time self-employment (49%), full-time salaried positions (20%) and non–general practice medical work (20%); • Preferred to work in urban areas (85%).	Female GPs in this age cohort: • Comprised 23% of all female GPs (the largest among all female age cohorts); • Preferred locum work (48%), part-time self-employment (18%) and part-time salaried work (16%); • Overwhelmingly preferred to work in urban areas (88%), however they also comprised the highest percentage of all female GPs who worked in rural areas (27%).	GPs in this age cohort: • Comprised 17.8% of the survey participants; • Preferred full-time (19%) and part-time (17%) self-employment and locum work (13%); • Worked 40.3hrs/wk; • Spent 59% of this time consulting with patients, 14% on patient-related paperwork, 8.4% on on-call duties, 5% on non–general practice medical work and 3% on educating other health professionals; • Comprised 14% of those GPs who intend to change their work arrangements in the next five years; • Would prefer to engage in full-time self-employment (25%), locum work (16%) and work overseas (12%); • Comprised 17% and 18% of all GPs who worked in rural and urban areas respectively; • Earned a median income of $100,000 and an average income of $100,300.

* 'Other' work arrangements noted were: GPs studying, medicolegal work, after-hours care, police work (DSAC), sport team work, insurance consultancy, school clinics, various public health clinics, radio preparations, rest home work, prison MO, working for organisations caring for disabled and handicapped people, surgery, College work, research, farm work, GP liaison, ACC work, health advisory, and private business.

There was a greater percentage of female GPs in this age cohort. The female GPs preferred part-time self-employment and locum work compared to their male counterparts who preferred full-time self-employment and full-time salaried positions. Some female GPs in this age cohort also took time off to raise a family. In five years, GPs in this cohort would like to engage in other types of work, locum work, full-time self-employment, and possibly work overseas.

3.2.3 Age cohort: GPs aged 46–55 years

This age cohort comprised 42% (748) of the survey participants, the largest of all the age cohorts. Fifty-six percent (417) were male GPs.

Table 4: Key findings of GPs in the 46–55 age cohorts

Age	Male (N=220)	Female (N=180)	(N=400) Summary
46–50	Male GPs in this age cohort: • Comprised 23% of all male GPs (the largest among all male age cohorts); • Preferred full-time self-employment (58%), non–general practice medical work (15%) and non-medical work (16%); • Preferred to work in urban areas (83%); • Had almost 16% working in rural areas; • Comprised the highest percentage of all male GPs working in rural areas (24%).	Female GPs in this age cohort: • Comprised 22% of all female GPs; • Preferred part-time (43%) and full-time (18%) salaried positions, and locum work (20%); • Overwhelmingly preferred to work in urban areas (92%).	GPs in this age cohort: • Comprised 22.2% of the survey participants (the highest among all age cohorts); • Preferred full-time (27%) and part-time (18%) self-employment, and locum work (9%); • Worked 41.9hrs/wk; • Spent 61% of this time consulting with patients, 15% on patient-related paperwork, 5% on on-call duties, and 4.5% on practice administration; • Comprised 18% of those GPs who intend to change their work arrangements in the next five years (highest percentage among all age cohorts); • Would prefer to engage in locum work (21%), other* types of work (20%), and work overseas (18%) in five-years' time; • Comprised 22.5% and 22% of all GPs who worked in rural and urban areas respectively; • Earned a median income of $100,000 and an average income of $106,800.
Age	**Male (N=197)**	**Female (N=151)**	**(N=348) Summary**
51–55	Male GPs in this age cohort: • Comprised 21% of all male GPs; • Preferred full-time self-employment (52%), full-time salaried positions (18%) and non-medical work (17%); • Preferred to work in urban areas; • Had almost 16% working in rural areas.	Female GPs in this age cohort: • Comprised 18% of all female GPs; • Preferred part-time (37%) and full-time (26%) self-employment, and non–general practice medical work (15%); • Overwhelmingly preferred to work in urban areas (87%).	GPs in this age cohort: • Comprised 19.4% of the survey participants; • Preferred full-time (27%) and part-time (15%) self-employment and non–general practice medical work (10%); • Worked 45.5hrs/wk; • Spent 60% of this time consulting with patients; 14% on patient-related paperwork; 7.5% on on-call duties, and 4% on practice administration; • Comprised 17% of those GPs who intend to change their work arrangements in the next five years; • Would prefer to engage in locum work (20%), part-time self-employment (17%) and work overseas (17%) in five-years' time; • Comprised 22% and 19% of all GPs who worked in rural and urban areas respectively; • Earned a median income of $120,000 and an average income of $119,100.

* 'Other' work arrangements noted were: GPs doing studies, medicolegal work, after-hours care, police work (DSAC), sport team work, insurance consultancy, school clinics, various public health clinics, radio preparations, rest home work, prison MO, working for organisations caring for disabled and handicapped people, surgery, College work, research, farm work, GP liaison, ACC work, health advisory, and private business.

There was a greater percentage of male GPs in this age cohort. The GPs, both males and females, preferred full-time self-employment, non–general practice work, part-time and full-time salaried positions and locum work. This

cohort had the highest percentage of GPs working in rural areas (44.5%).[4] Also in their respective gender groups, this cohort had the highest percentage of male GPs (45%) and female GPs (46%) working in rural areas. The cohort also had the highest percentage of GPs (34%) intending to change their work arrangements in the next five years. In five years, GPs in the cohort would like to engage in other types of work, locum work, part-time self-employment, and possibly work overseas.

3.2.4 Age cohort: GPs aged 56–65 years

This age cohort comprised 19% (342) of the survey participants. Seventy-five percent (256) were male GPs.

Table 5: Key findings of GPs in the 56–65 age cohorts

Age	Male (N=166)	Female (N=56)	(N=222) Summary
56–60	Male GPs in this age cohort: • Comprised 17% of all male GPs; • Preferred full-time self-employment (57%), non–general practice medical work (13%) and full-time salaried positions (12%); • Preferred to work in urban areas (83%); • Had 14% working in rural areas.	Female GPs in this age cohort: • Comprised 7% of all female GPs; • Preferred full-time self-employment (30%), locum work (20%), and part-time self-employment (18%); • Overwhelmingly preferred to work in urban areas (88%).	GPs in this age cohort: • Comprised 12% of the survey participants; • Preferred full-time self-employment (35.5%), full-time salaried positions (9%) and non–general practice medical work (8.3%); • Worked 50 hrs/wk (the highest of any age cohort); • Spent 58% of this time consulting with patients, 14% on patient-related paperwork, 9% on on-call duties, and 4.6% on other types of work; • Comprised 16% of those GPs who intend to change their work arrangements in the next five years; • Would prefer to retire (26%), engage in locum work (19%), and part-time self-employment (15%) in five-years' time; • Comprised 13% and 12% of all GPs who worked in rural and urban areas respectively; • Earned a median income of $140,000 and an average income of $129,000.
Age	**Male (N=90)**	**Female (N=30)**	**(N=120) Summary**
61–65	Male GPs in this age cohort: • Comprised 9% of all male GPs; • Preferred full-time self-employment (47%), locum work (22%) and non–general practice medical work (16%); • Preferred to work in urban areas but almost 23% of them worked in rural areas.	Female GPs in this age cohort: • Comprised 4% of all female GPs; • Preferred locum work (37%) and full-time self-employment (23%); • Overwhelmingly preferred to work in urban areas (83%).	GPs in this age cohort: • Comprised 7% of the survey participants; • Preferred full-time self-employment (28%), locum work (18%) and non–general practice medical work (10%); • Worked 45 hrs/wk; • Spent 60% of this time consulting with patients; 11% on patient-related paperwork; 12% on on-call duties, and 4.7% on other types of work; • Comprised 10% of those GPs who intend to change their work arrangements in the next five years; • Would prefer to retire (59%) in five-years' time; • Comprised 22% and 19% of all GPs who worked in rural and urban areas respectively; • Earned a median income of $120,000 and an average income of $106,200.

* 'Other' work arrangements noted were: GPs doing studies, medicolegal work, after-hours care, police work (DSAC), sport team work, insurance consultancy, school clinics, various public health clinics, radio preparations, rest home work, prison MO, working for organisations caring for disabled and handicapped people, surgery, College work, research, farm work, GP liaison, ACC work, health advisory, and private business.

[4] Rurality on the survey form was determined by the respondent, firstly by indicating their perception of rurality (self-identification) and secondly by indicating their rural ranking score as per the Ministry of Health's rural ranking scale (RRS).

Three quarters of GPs in this age cohort were males. The GPs, both males and females, preferred full-time self-employment, full-time salaried positions, non–general practice work, and locum work. This cohort, especially those 56–60 years, spent the greatest number of hours per week (50hrs) in general practice or related work. This cohort also spent 9–12% of their time on on-call duties; the highest of all age cohorts. In five years, the majority in this cohort intend to retire.

3.2.5 Age cohort: GPs aged 66–71+ years

This age cohort comprised 4% (77) of the survey participants. Eighty-three percent (64) were male GPs.

Table 6: Key findings of GPs in the 66–71+ age cohorts

Age	Male (N=40)	Female (N=8)	(N=48) Summary
66–70	Male GPs in this age cohort: • Comprised 4% of all male GPs; • Preferred locum work (30%) and full-time self-employment (25%); • Preferred to work in urban areas (85%); • Had almost 15% working in rural areas.	Female GPs in this age cohort: • Comprised 1% of all female GPs; • Preferred part-time salaried positions (38%); • Overwhelmingly preferred to work in urban areas (100%).	GPs in this age cohort: • Comprised 3% of the survey participants; • Preferred locum work (23%), full-time (20%) and part-time (12%) self-employment and other types of work (12%); • Worked 39.2hrs/wk; • Spent 69% of this time consulting with patients, 12.5% on patient-related paperwork, 5.6% on on-call duties, and 2.3% on practice administration; • Comprised 4% of those GPs who intend to change their work arrangements in the next five years; • Would prefer to retire (64%) in five-years' time; • Comprised 2.7% and 2.7% of all GPs who worked in rural and urban areas respectively; • Earned a median income of $80,000 and an average income of $85,200.
Age	**Male (N=24)**	**Female (N=5)**	**(N=29) Summary**
71+	Male GPs in this age cohort: • Comprised 2.5% of all male GPs; • Preferred locum work (33%) and full-time self-employment (25%); • Preferred to work in urban areas • Had almost 16% working in rural areas.	Female GPs in this age cohort: • Comprised less than 1% of all female GPs; • Preferred locum work (60%); • Overwhelmingly preferred to work in urban areas (87%).	GPs in this age cohort: • Comprised 2% of the survey participants; • Preferred locum work (37%) and full-time self-employment (20%); • Worked 34.8hrs/wk; • Spent 72% of this time consulting with patients; 15% on patient-related paperwork; 3% on on-call duties, and 4% on a sub-speciality; • Comprised 2.5% of those GPs who intend to change their work arrangements in the next five years; • Would prefer to retire (82%) in five-years' time; • Comprised less than 1% and 2% of all GPs who worked in rural and urban areas respectively; • Earned a median income of $100,000 and an average income of $88,500.

* 'Other' work arrangements noted were: GPs doing studies, medicolegal work, after-hours care, police work (DSAC), sport team work, insurance consultancy, school clinics, various public health clinics, radio preparations, rest home work, prison MO, working for organisations caring for disabled and handicapped people, surgery, College work, research, farm work, GP liaison, ACC work, health advisory, and private business.

This cohort comprised the lowest percentage (4%) of GPs in the workforce. More than 80% of GPs in this age cohort were males. The GPs, both males and females, preferred full-time and part-time other types of work and locum work. This cohort also spent 69–72% of their time consulting with patients; the highest of all age cohorts. In five years, the majority in this cohort intend to retire. This age cohort is likely to see an increase in its percentage of the workforce as many older GPs may decide to defer retirement due to good health and a demand for their services.

4. Emerging Trends

The College has collected workforce data from its membership since 2003. The 2003 survey investigated a representative sample of approximately 18% (500) of GPs with a response rate of 54%, whereas the 2005, 2006, 2007 and the 2008 survey were sent to all members with response rates of 60% (2057); 49% (1555); 59% (1995); and 52% (1799) respectively. The 2006 data is from a mini-survey that asked members to answer two questions on workforce and three questions on the College's operations from the 2005 survey questions. Responses from all these surveys will be compared in this section.

4.1 Gender (2003–2008)

Since 2000, more female medical graduates have chosen general practice as their vocation than previously. Their increased GP workforce participation is shown in increasing College membership; over 44% of all College members are female.

Table 7: Number of responses to workforce surveys 2003–2008

Gender	2003 N (%)	2005 N (%)	2006 N (%)	2007 N (%)	2008 N (%)
Male	150 (56)	1174 (57)	885 (57)	1098 (55)	961 (53)
Female	115 (43)	883 (43)	670 (43)	897 (45)	838 (47)
Unspecified	3 (1)	–	–	–	–
TOTAL	268	2057	1555	1995	1799
Response rate	10%	60%	49%	59%	52%

Similarly, since 2005, the number of female GPs participating in the College's membership survey has increased by 4% (Table 7). This trend is likely to continue as more females are joining the GP workforce and replacing mostly older male GPs who will retire in the coming decade.

4.2 Age (2003–2008)

The mean age of participants in the 2003 survey was approximately 47 years, in 2005 it was 48 years, and in 2007 and 2008 it was 49 years. This suggests that the GP workforce is ageing.

Table 8: Age of respondents to workforce surveys 2003–2008

Age*	2003 N (%)	2005 N (%)	2006 N (%)	2007 N (%)	2008 N (%)
35 and under	19 (7.1)	139 (6.8)	98 (6.3)	156 (7.9)	139 (7.7)
36–45	96 (35.8)	686 (33.3)	500 (32.1)	586 (29.3)	493 (27.4)
46–55	90 (33.6)	826 (40.2)	618 (39.7)	814 (40.8)	748 (41.6)
56–65	52 (19.4)	314 (15.2)	275 (17.7)	353 (17.7)	342 (19)
66 and over	8 (3.0)	78 (3.8)	58 (3.8)	79 (4)	77 (4.3)
Unspecified	3 (1.1)	14 (0.7)	6 (0.4)	7 (0.3)	–
TOTAL	268 (100)	2057 (100)	1555 (100)	1995 (100)	1799 (100)

* These categories have been slightly modified to make the comparison of data more compatible, hence the '34 and under' now reads '35 and under', and '35–44' now reads '36–45', etc. This is one of the changes that resulted from a review of the 2003 questionnaire. Since 2005, the above age categories have been standardised for subsequent surveys. This change is not expected to have a significant impact on the overall outcome of the comparisons between the surveys.

In 2008, there were more GPs aged 46 and over than there were in 2007, 2005 and 2003 (Table 8). There has also been a substantial decrease in the percentage of 36–45-year-old GPs since 2003. This decrease could be attributed to fewer GP training places during the mid-90s to the mid-2000s. In 2007–09, GP training places have more than doubled.

More than half (57%) of all participants have been in general practice for more than 16 years. As the GP workforce ages, this percentage is likely to increase. Given the demographics of the workforce, there are not enough GPs coming through GP training to replace those who will soon be leaving general practice. GP training places may need further increases in the short to medium term.

4.3 Ethnicity and international medical graduates (2003–2008)

The GP workforce consists of many ethnic groups. Generally, NZ European representations in the surveys were slightly above their actual representation in the College (57%) and in New Zealand's overall population (59%). New and minority ethnic categories often had too few members to be listed separately (Table 9). GPs from all ethnic groups were represented well above their overall representation within New Zealand's population, with the exception of Māori and Pasifika GPs. Māori GPs constitute approximately 3% of the GP workforce but are 14% of New Zealand's overall population.

Table 9: Ethnicity of respondents to workforce surveys 2003–2008

ETHNICITY	2003 N (%)	2005 N (%)	2006 N (%)	2007 N (%)	2008 N (%)
NZ European	190 (70.9)	1323 (64.3)	977 (62.8)	1209 (60.6)	1121 (62.3)
European*	–	217 (10.5)	180 (11.6)	239 (12.0)	208 (11.6)
Chinese	12 (4.5)	88 (4.3)	62 (4.0)	100 (5.0)	83 (4.6)
Indian**	10 (3.7)	93 (4.5)	58 (3.7)	81 (4.1)	76 (4.2)
South African	–	39 (1.9)	49 (3.2)	69 (3.5)	59 (3.3)
Unknown	7 (2.6)	93 (4.5)	47 (3.0)	62 (3.1)	46 (2.6)
Sri Lankan	–	57 (2.8)	50 (3.2)	60 (3.0)	50 (2.8)
Other***	45 (16.8)	10 (0.5)	21 (1.4)	20 (1.0)	21 (1.1)
Māori	4 (1.5)	44 (2.1)	37 (2.4)	43 (2.2)	33 (1.8)
Australian	–	30 (1.5)	22 (1.4)	39 (1.9)	35 (1.9)
Other Asian†	–	30 (1.5)	26 (1.8)	38 (1.9)	39 (2.2)
Middle Eastern††	–	14 (0.7)	10 (0.6)	17 (0.8)	16 (0.9)
Pacific people		19 (0.9)	14 (0.9)	18 (0.9)	12 (0.7)
TOTAL	268 (100)	2057 (100)	1555 (100)	1995 (100)	1799

Note: Ethnicities that reported 10 members or fewer have been included in an ethnic category compatible with Statistic New Zealand's ethnic classifications. This is to preserve the confidentiality of some participants in this survey. The above ethnicity categories (2005–2007) have been slightly adjusted to reflect this change.

* Includes English, British, Irish, Scottish, Americans, Canadians and Germans.

** Includes Fiji Indians.

*** Includes ethnicities with fewer members (10 members or fewer) represented in this Survey: Africans, Zimbabweans, Fijians, Tongans, Samoans, Cook Island Maori, Other Pacific Islanders and Latin Americans.

† Includes South East Asians, Bangladeshis, and Filipinos.

†† Includes Iraqis and Egyptians

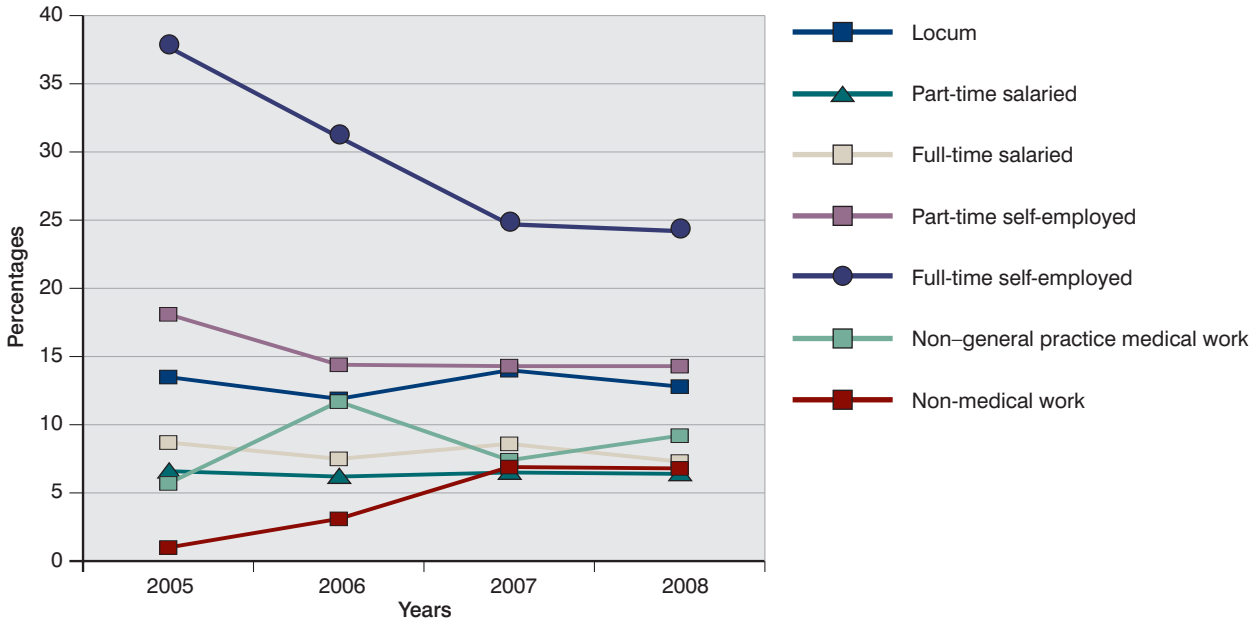
In the 2008 survey 32% of participants were international medical graduates (IMGs). They came from most of the ethnic backgrounds as listed in Table 9, with Europeans (27%) and New Zealand Europeans (25%) constituting the majority.[5] The majority of IMGs came from the United Kingdom (UK) (44%), South Africa (18%), and Australia (11%). Sixteen percent of IMGs were from the Indian sub-continent (India, Sri Lanka, and Bangladesh).

The Medical Council of New Zealand reported that 35–40% of all GPs are IMGs (MCNZ, 2004–2008); NZMA, 2004). While the percentage of IMGs has remained consistent over this period of time, it is difficult to predict the percentage in 10 years time when the impact of an ageing population and workforce starts to take real effect. In 2008, the mean and median age of IMGs was 50 and 49 respectively. If New Zealand is not able to train and retain local medical graduates then IMGs may be the only alternative. However, some analysts are suggesting the creation of new roles (professional groups) to fill the gaps left by an ageing medical workforce, and to combat the increase in the disease burden due to ageing (MRG, 2009; HWAC, 2005)

4.4 Work arrangements (2005–2008)

The percentage of self-employed GPs appears to be declining (Graph 1). Since 2005, approximately 30% of self-employed GPs have chosen other work arrangements.

Graph 1: Emerging trends: The top seven work arrangements of GPs (2005–2008)



More research is required to determine whether this decrease represents a genuine change in the business model or if it is a result of other factors. Self-employment has in the past been the mainstay of many GPs, but may now be a less attractive option. Another possible reason for this decline could be the introduction of PHOs that have been created to deliver primary health care. Some PHOs now own their own premises and employ doctors and other health professionals.

[5] This could suggest that some GPs of European origin have come to identify themselves as New Zealand Europeans or that a significant portion of New Zealand Europeans were/are going overseas to get medical training.

The decline in self-employment has been accompanied by an increase in GPs doing non–general practice medical work, non-medical work, unpaid work, academia, and other types of work within and outside of the health sector (Graph 1 and Table 10). Since 2005, GPs in non–general practice medical work such as hospital work and non medical work such as management positions within DHBs, and PHOs increased substantially.

Table 10: Work arrangements of respondents to workforce surveys 2005–2008

WORK ARRANGEMENTS	2005 N (%)	2006 N (%)	2007 N (%)	2008 N (%)
Locum GP	311 (13.5)	253 (11.9)	383 (14.0)	334 (12.8)
Part-time salaried GP	153 (6.6)	132 (6.2)	177 (6.5)	166 (6.4)
Full-time salaried GP	200 (8.7)	159 (7.5)	235 (8.6)	190 (7.3)
Part-time self-employed GP	416 (18.1)	307 (14.4)	393 (14.3)	372 (14.3)
Full-time self-employed GP	868 (37.7)	664 (31.1)	678 (24.7)	632 (24.2)
Sub-specialised in general practice	40 (1.7)	75 (3.5)	91 (3.3)	101 (3.9)
Non–general practice medical work (e.g. Hosp. work)	131 (5.7)	249 (11.7)	204 (7.4)	239 (9.2)
Non-medical work (e.g. mgmt with DHB, PHO, etc.)	23 (1.0)	66 (3.1)	191 (6.9)	177 (6.8)
Working overseas	34 (1.5)	20 (0.9)	22 (0.8)	30 (1.1)
Unpaid work (e.g. Community work)	9 (0.4)	105 (4.9)	131 (4.8)	109 (4.2)
Academia	–	–	97 (3.5)	101 (3.9)
Retired	15 (0.7)	18 (0.8)	13 (0.5)	8 (0.3)
Other*	104 (4.5)	85 (4.0)	129 (4.7)	146 (5.6)
TOTAL	2304 (100)	2133 (100)	2744 (100)	2605 (100)

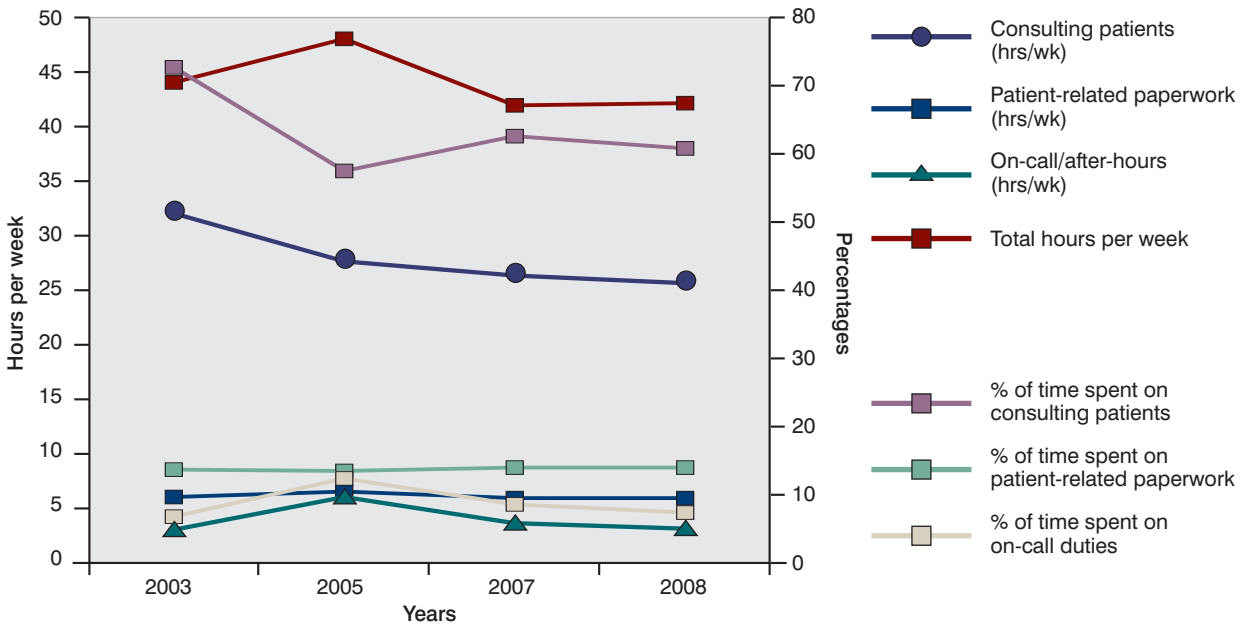
* 'Other' work status noted are: GPs doing studies, medicolegal work, after-hours care, police work (DSAC), sport team work, insurance consultancy, school clinics, various public health clinics, radio preparations, rest home work, prison MO, working for organisations caring for disabled and handicapped people, surgery, College work, research, farm work, GP liaison, ACC work, health advisory, and private business.

Male GPs continue to constitute the majority of self-employed GPs but their percentages are declining. In 2005, approximately 60% of all male GPs were self-employed compared to approximately 40% in 2008. Similarly, in 2005, approximately 50% of all female GPs were self-employed compared to 37% in 2008. The decrease in self-employment has been accompanied by an increase in sub-speciality, non–general practice medical work, working overseas, unpaid work and other types of work for both genders.

4.5 Hours worked (2005–2008)

GPs have in the past reported concerns over having to work long hours (Pande & Stenson, 2008; RNZCGP Membership Survey 2005 Report II, 2006). However this seems to be changing. In 2007 and 2008, GPs reported working an average of 42 hours per week; a decrease of two hours since 2003, and six hours since 2005 (Graph 2).

Graph 2: Emerging trends: Hours worked per week (2005–2008)



However, the reduction in hours worked per week has not affected the delivery of primary health care to patients as the percentage of time spent on consulting with patients has increased since 2005, while the hours spent on on-call duties has decreased. In many urban centres, on-call or after-hours care is provided by third parties contracted to PHOs. There are also small increases in the percentage of time spent on activities such as patient-related paperwork and other types of work (Table 11).

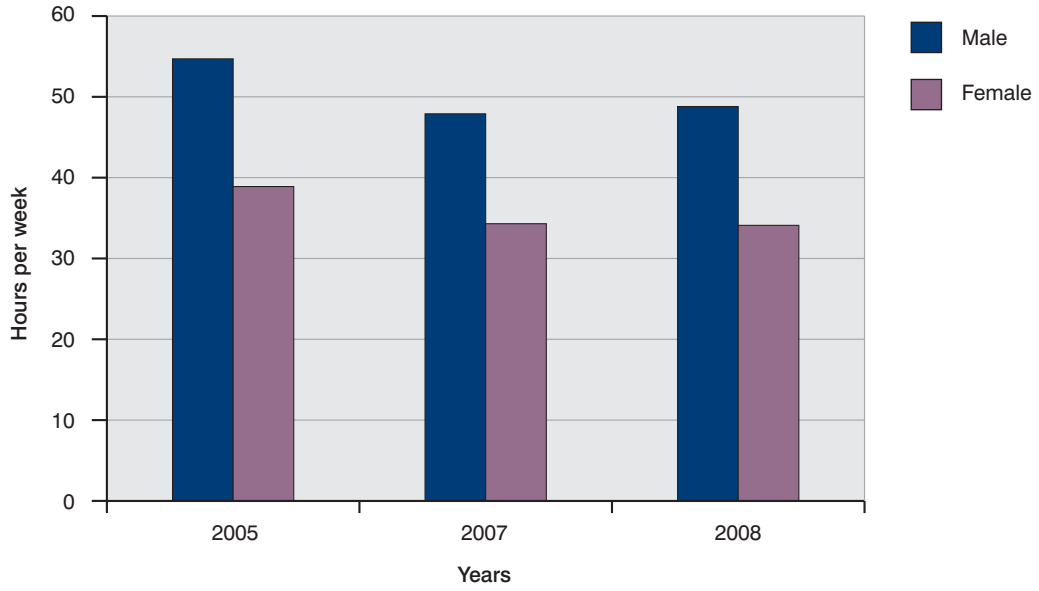
Table 11: Hours worked per week of respondents to workforce surveys 2003–2008

ACTIVITIES	2003 N (%)	2005 N (%)	2007 N (%)	2008 N (%)
Consulting in GP (excluding on-call)	32 (72.7)	27.6 (57.5)	26.3 (62.6)	25.6 (60.8)
On patient-related paperwork (additional to consulting)	6* (13.7)	6.5 (13.5)	5.9 (14.0)	5.9 (14.0)
On-call (after-hours care)	3 (6.8)*	6 (12.4)	3.6 (8.6)	3.1 (7.4)
Practice administration	–	2 (4.2)	1.4 (3.3)	1.5 (3.6)
Sub-specialty work	–	–	0.6 (1.5)	0.9 (2.1)
Non–general practice medical work	–	2.2 (4.6)	1.3 (3.2)	1.6 (3.8)
Educating other health practitioners	–	0.8 (1.6)	0.5 (1.3)	0.6 (1.4)
Professional development	3 (6.8)	1.9 (3.9)	1.2 (3.0)	1.4 (3.3)
Collegial support	–	0.2 (0.5)	0.2 (0.4)	0.2 (0.5)
Others	–	0.8 (1.8)	0.9 (2.1)	1.3 (3.1)
TOTAL	44 (100)	48 (100)	41.9 (100)	42.1 (100)

* The figure for patient-related paperwork also includes time spent on practice administration work. The average time spent on any type of administration work increased by about 2.5 hours to 8.5 hours in 2005 when compared to six hours in 2003.

In 2008, male GPs slightly increased their hours per week in general practice while female GPs have reduced their hours (Graph 3). Male GPs have reduced their hours worked per week by approximately six hours since 2005 compared to female GPs who have reduced theirs by approximately 4.5 hours in the same period. Both male and female GPs have increased the percentage of hours spent on patient consultations and reduced the hours spent on on-call duties (after-hours care).

Graph 3: Emerging trends: Hours worked per week by gender (2005–2008)



Professional development remains important for maintaining annual practising certificates, maintaining quality standards, and providing patients with best possible care. Male GPs and female GPs have slightly reduced the percentage of time they spend on crucial activities such as professional development and practice administration. Many medium to large practices have practice managers and office staff to assist with administration.

Since 2007, GPs in the 31–50 age cohorts have reduced their average working hours per week whereas GPs in the 25–30 and 51–71+ have increased their average hours (Table 12). GPs in the 46–65 age cohorts spent over 1 FTE per week in general practice, with GPs in the 56–60 age cohort working almost 1.3 FTEs on average. This trend is likely to continue as many in the 46–65 age cohorts preferred self-employment; full-time self-employed GPs spent an average of 53 hours per week in general practice.

Table 12: Hours worked (by age) of respondents to workforce surveys 2005–2008

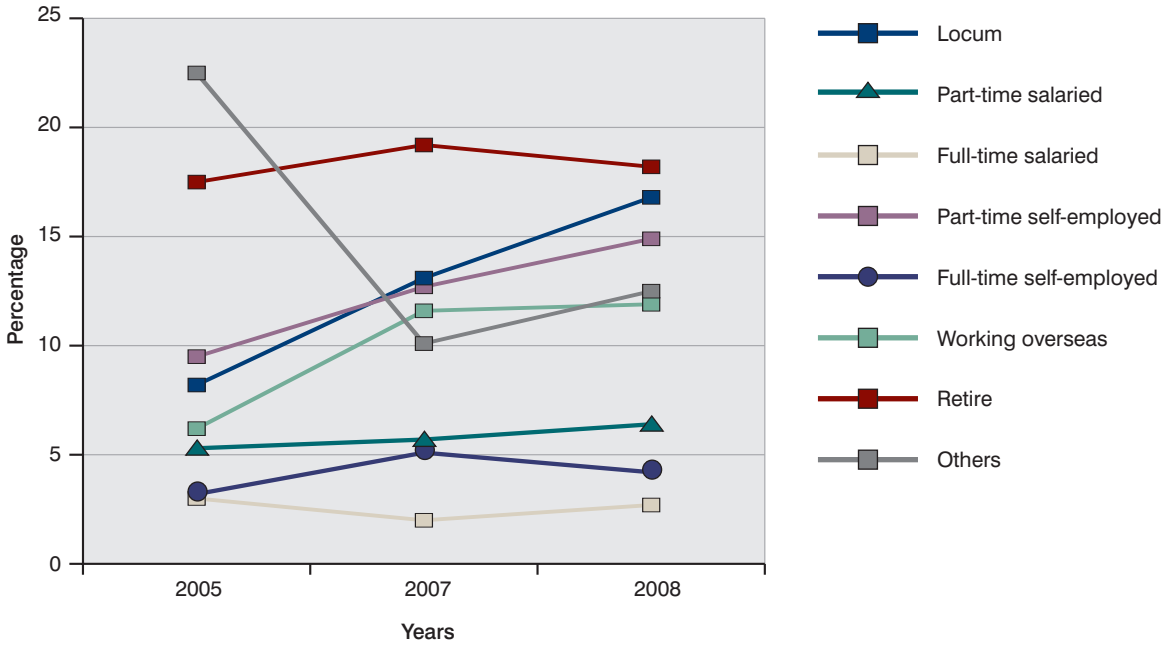
HOURS WORKED PER WEEK	2005	2007	2008
Age	Ave hrs/wk	Ave hrs/wk	Ave hrs/wk
Average	48.0	41.9	42.1
25–30	43.4	31.8	39.0
31–35	39.5	34.8	33.5
36–40	40.5	35.3	33.4
41–45	46.3	41.1	40.3
46–50	50	43.8	41.9
51–55	53.2	44.6	45.5
56–60	53.1	48.5	50.0
61–65	51.1	43.1	44.7
66–70	43.1	37.8	39.2
71+	33.7	25.1	34.8
UNK	55.6	36.9	–

Between 2005 and 2008, GPs in all work arrangements, except for those engaged in part-time and locum work, spent more than 1.1 FTEs in general practice. Those GPs working the longest were in full-time self-employment and salaried work, in non–general practice medical work, non-medical work, and academia.

4.6 Future work intentions (2005–2008)

In five years, nearly a fifth of GPs intend to retire (Graph 4). This is consistent with the percentage of GPs who are over the age of 56 years. Of those GPs who intend to continue working, locum work, part-time self-employment, working overseas, and part-time salaried positions are favoured. Full-time self-employment and salaried positions, (and sub-specialties, non–general practice work, non-medical work, academia, and unpaid work—not in Graph 4) were favoured by less than 5% of respondents.

Graph 4: Emerging trends: Intended change in work arrangements in five years (2005–2008)



Since 2005, 55–67% of participants stated a factor that is likely to influence their future work intentions. In 2008, over a fifth of respondents (262) mentioned retirement as a factor likely to influence their future work intentions (Graph 5). Male GPs aged ≥50 years comprised the majority of GPs likely to retire in the near future. Since 2005, the percentage of GPs intending to retire has gradually increased.

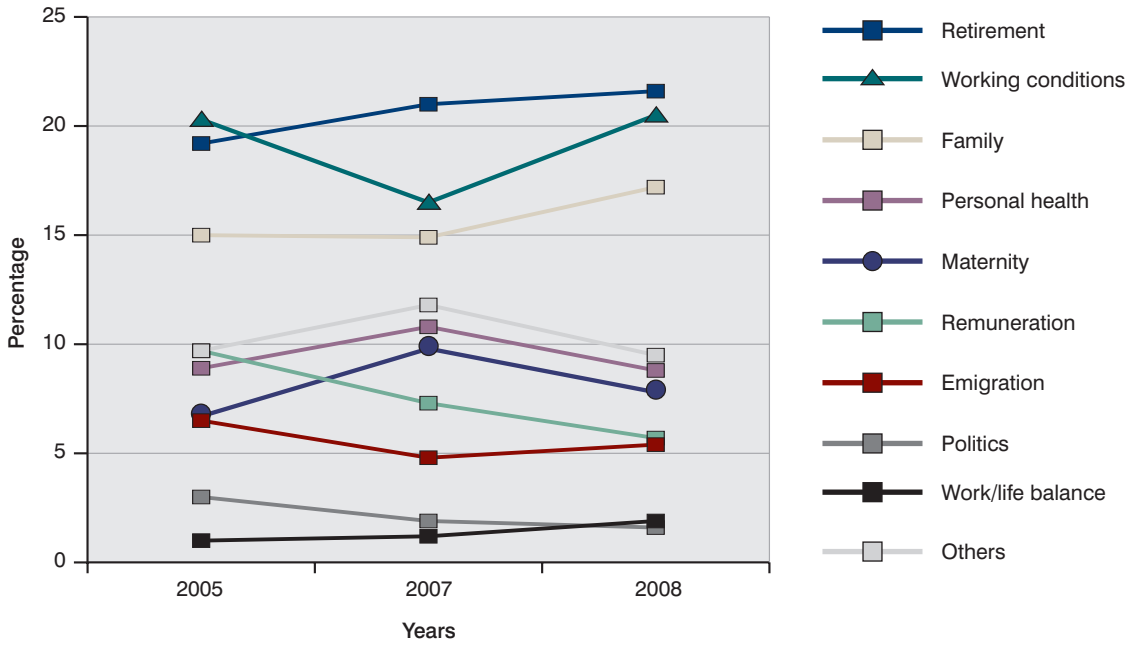
GPs also stated their working conditions (lack of job satisfaction, ability to attract locums, increasing paperwork, high level of bureaucracy, increasing compliance costs, etc.) as factors likely to influence their future work intentions. Family considerations (childcare, children's educational needs, spousal work commitments, care for elderly parents, etc.) are also a major factor; more female GPs stated this as an issue likely to influence their future employment decisions.

In the surveys, GPs reported poor health due to ageing, illness, exhaustion, work-related stress, and burnout as factors likely to force many to change their future working arrangements.

Maternity is an important factor for temporary change among younger female GPs (average age of 34 years). Most are likely to return to the workforce as their children grow older.

The level of remuneration was a major concern; however, since 2007 fewer GPs have stated it as a factor likely to influence their future work intentions. Emigration for the purpose of paid and voluntary work is an option some GPs would like to explore in the near future. Generally, more male GPs are likely to emigrate. Some female GPs plan to do voluntary work overseas in the near future.

Graph 5: Emerging trends: Factors likely to influence future work intentions (2005–2008)



The politics in health and achieving a work/life balance are minor factors that could influence some GPs when considering their future work intentions. Approximately 10% of GPs gave various reasons such as their ability to take holidays, the need to increase/decrease hours, doing further studies, career development, writing books, committing to religion, winning lotto, etc. that may influence their future work intentions.

As in previous surveys, participants continued to rate their practice facilities and equipment, their engagement with their patient community, and their ability to provide after-hours care very highly. Participants also noted that their financial remuneration and their ability to take holidays had substantially improved. However, finding locums remains an issue for more than 60% of participants.

The following section will discuss some of the key findings of this report.

5. Discussion

The key findings and trend analysis of the College's 2008 membership survey report raised the following main issues:

- Ageing workforce
- Feminisation of the workforce
- Increasing number of IMGs
- Decreasing number of self-employed GPs
- Some GPs choosing other work arrangements
- Reduction of hours GPs spend in traditional general practice activities.

5.1 Ageing workforce

Approximately 23% of the 2008 GP workforce was aged 56 years and over. Since 2005, the College's membership survey reports have shown increases in the number of GPs aged 56 years and over. In 2005, most GPs in this age group indicated a desire to retire within the next five years (RNZCGP 2007 Membership Survey Report Part I & II, 2009; Pande, 2008; RNZCGP 2005 Membership Survey Report Part II, 2006).

Another indicator of an ageing GP workforce is the increased mean and median age; in 1998 the mean and median age of GPs was 42 years each, while in 2008 it had gone up to 49 years. Since 2005, the mean and median age increased by one year. This trend is likely to continue as the majority of GPs are aged 46 years and over. Male GPs comprise the majority who are likely to retire in the next decade. The recently published *Status and Activities of General Medical Practices* (Raymont & Cumming, 2009), the Medical Council of New Zealand's Medical Workforce Report 2008, and the New Zealand Medical Association's GP Workforce update (2009) all support the above trends.

The GP workforce will diminish in the future due to ageing and increased GP retirements (Raymont & Cumming, 2009; Gorman et al., 2009; Pande, 2008; Pande & Stenson, 2008). Compounding the challenge is the ageing of the general population that will put pressure on the current provision of health care and would require substantial increases in the health care workforce (NZIER, 2005). Increases in chronic health conditions among the elderly are likely to significantly increase GPs' workload.

Most of the literature defines older/mature workers as 45 years and over (Department of Labour, 2006). While this definition may have relevance among a variety of work groups, highly skilled workers such as GPs are more likely to consider a higher age range that is closer to the retirement age (65 years) as a better definition of 'older/mature' workers. This is reflected in the RNZCGP survey findings as more GPs aged 56 years and over considered retirement as a priority option in the future.

On current estimates, a 56-year-old male is likely to live up to the age of 81; a 56-year-old female will live till 84 (Statistics New Zealand, 2009). Given the increasing life expectancy mainly due to public health initiatives, older workers may prefer to work for a longer period possibly because they enjoy the chance to work or need to work due to resource issues (CDC, 1999; McNair, 2006). Arguably among GPs, the former reason maybe a greater motivator. New Zealand, like many other developed countries, has to develop strategies and programmes to engage and retain older workers (including GPs) in the workforce.

As highly skilled workers, the majority of GPs will decide for themselves when they retire. Given the shortages in the workforce, older GPs may face lesser barriers to continue or to rejoin the workforce. The main barriers are likely to be the continued maintenance of professional standards and their physical capacity to practise safely.

The 2008 RNZCGP survey showed that other than retirement, factors that are likely to affect the future work intentions of GPs included their working conditions, family commitments, personal health, maternity, remuneration, emigration, politics, work/life balance, and other individualistic pursuits. Arguably each of these factors could be approached strategically to improve retention rates; a small but significant percentage of those intending change are younger GPs.

Flexibility is an important overarching strategy that applies to most of the 'factors' mentioned above. Older GPs are likely to work fewer sessions, choosing when and how much time they spend in practice (RNZCGP 2005–2009; Raymont & Cumming, 2009). Anecdotal evidence suggests that many older GPs have elderly parents who need regular care. Many have one or more personal health issues that impede them from full-time practice. A conscious decision by stakeholders to allow for flexible working hours and conditions could help retain more GPs who would otherwise retire/leave the workforce prematurely.

Financial incentives could also entice some older GPs to continue working. Incentives could include shorter working hours while receiving full pay, reduced tax rates or increasing tax credits, in-work training grants, increased govt/employer contributions to superannuation funds, one-off payments as a gesture of goodwill, and flexible retirement schemes (Mifsud, 2005; Department of Labour, 2006; European Foundation for the Improvement of Living and Working Conditions, 2007; Raymont & Cumming, 2009).

While the average hours worked per week has declined, many GPs still reported working excessive hours, are burdened with increased bureaucratic demands and compliance costs, experience frustration and stress/burn-out, and feel under-valued compared to their hospital-based specialists/colleagues. Initiatives to address these issues would also help retain some GPs and make general practice more attractive to a new generation of potential GPs.

5.2 Feminisation of the GP workforce

While general practice as a speciality (compared to the various hospital-based specialities) attracts the highest percentage of female medical graduates (34% in 2006), there has been a decline in the percentages entering general practice since 2001 (MCNZ, 2008; Lawrence & Poole, 2001; Fenwicke, 2004; EEO, 2009; NZMA 2009). A US study showed that general practice/family medicine and surgery were not favoured by men or women because of longer and rigid working hours (Society for Canadian Women in Science and Technology, 2008). General practice may not be as attractive to female medical graduates as has been previously perceived, even though there are more younger female GPs than male GPs (≤45 years) in New Zealand.

The feminisation of the workforce (including general practice) is seen as a Generation X phenomenon (McKinstry et al., 2006; Schofield & Beard, 2005). Female GPs are more likely to be aged 40 years and under. Increasing numbers of female GPs pose certain challenges. They have traditionally worked fewer hours than male GPs (Pande & Stenson, 2008; MCNZ, 2008; NZMA, 2004). In the 2008 survey, female GPs spent an average of 34hr/wk in general practice, approximately 15 hours less than the average hours worked by male GPs. The main reason for this difference is that many female GPs prioritise raising a family early on in their career, and later choose to work part-time or reduced hours as their children grow (EEO Trust, 2009; RNZCGP, 2005–2009).

While investigating the impact of feminisation on the Scottish GP workforce, McKinstry et al. (2006) imply that women currently in their 30s will choose to work longer hours in their 40s and 50s than women of that age currently

do. The 2007 survey data clearly suggests female GPs prefer part-time and locum work. However, it is possible, as McKinstry suggests, that as younger female GPs get older and have fewer family responsibilities, it is likely that they may work longer hours.

One of the greatest challenges will be faced when the majority of older male GPs who spend the most hours in general practice retire in the next decade. NZMA (2004) and McKinstry (2006) noted that the increasing number of female GPs working part-time is putting pressure on male GPs to increase their hours and will require an increase in the number of GPs to maintain the same level of service. However more longitudinal data is required to explore such phenomenon (McKinstry, 2006).

For the past five years, female medical graduates are the majority entrants into the General Practice Education Programme Stage 1. This trend is likely to continue as the majority of medical students in New Zealand are females (www.educationcount.govt.nz; Fenwicke, 2004).

5.3 Increasing number of IMGs

IMGs constitute a substantial portion of the GP workforce. In the 2008 College survey, 32% of participants were IMGs. The Medical Council of New Zealand (MCNZ) in their 2008 Workforce Report noted that 41% of the GP workforce was IMGs. Some IMGs work in New Zealand for short periods of time and therefore obtain a provisional registration with the MCNZ. These IMGs often do not become members of College and are therefore excluded from any workforce surveys either done by the College or any other institution. According to the MCNZ's 2006 Annual Report, approximately 2100 doctors were either in Provisional General or Provisional Vocational or Special Purpose or Temporary registers. Of these, approximately 40% are thought to be working in general practice.

The College's 2006 membership survey report showed that 48% of IMGs work in rural general practice based mostly in the North Island of New Zealand. Most of the IMGs in general practice prefer to do locum work, part-time and full-time salaried work. While New Zealand is heavily reliant on IMGs, there has been pressure to train more doctors locally to meet the demand. While it is acknowledged that IMGs are a valuable and significant part of the GP workforce, the long-term dependence on recruitment of IMGs is risky as the shortage of doctors in many OECD countries is increasing competition for them in the global market. There is potential for this competition to escalate the cost of health care. Also there are ethical concerns about recruiting doctors from developing and under-developed nations who need them more.

5.4 Decreasing number of self-employed GPs

Self-employment has in the past been the mainstay of GPs in New Zealand. The 2008 survey shows that self-employed GPs now constitute only 39% of the GP workforce compared to 56% in 2005. If representative, this decrease is substantial, and can be attributed to the changing environment in the primary health care sector. The introduction of PHOs to deliver primary health care has seen some GPs opting for salaried positions instead of self-employment (Pande & Stenson, 2008).

Previous College surveys (2003–2007) noted many GPs were dissatisfied with the level of bureaucracy and compliance costs associated with being self-employed (Pande, 2008; Pande & Stenson, 2008). The NZMA (2004) reported that many GPs expressed frustration at the high administrative burden and high compliance costs imposed on general practice by new and existing regulations. In the PHO environment, many practices with three or more GPs have a practice manager and other staff to assist with some of the administration (RNZCGP, A Profile of General Practice in New Zealand, 2008). Arguably, GPs who wanted to concentrate on patient care may have found this aspect of PHOs attractive.

Another possible reason for a decline in self-employed GPs is the association between self-employment and working longer hours. In 2005, GPs worked 48 hrs/wk on average, whereas full-time self-employed GPs worked 59 hrs/wk, and part-time self-employed GPs worked 37 hrs/wk. In 2008, the hours worked per week improved substantially from the work/life balance point of view; the average hrs/wk was 42 hours; full-time self-employed GPs averaged 53 hrs/wk and part-time self-employed GPs averaged 33 hrs/wk. While the number of hours worked per week decreased, a greater percentage was spent on patient consultations than previously.

It is unclear what portion of the GP workforce will remain self-employed, and what would be their models of delivery of care. It is also unclear what the government and stakeholder expectations are with regards to the composition of the workforce from the viewpoint of employment options. However, it is clear that a major shift is occurring where other employment options such as locum, salaried, sub-specialities, non–general practice and non-medical work are gaining favour. From the College's perspective, quality and continuity of care are integral to the provision of primary health care. All the changes occurring in the workforce and delivery of care need to reflect these expectations.

5.5 GPs are choosing other work arrangements

The decline in self-employment has been accompanied by an increase in locums, salaried GPs, sub-specialised GPs, GPs doing non–general practice medical work, non-medical work, unpaid work, academia and other types of work within and outside of the health sector (Pande & Stenson, 2008). While GPs are open to choose the type of work they do, there is some concern about GPs who do no general practice work but are counted as GPs in many surveys and on the MCNZ register. This could lead to an overestimation of the number of GPs doing general practice work. While the MCNZ does report data on doctors' main worksite, its utility and relevance to workforce planning is unclear.

5.6 Reduction of hours GPs spend in general practice

Both male and female GPs have reduced the hours spent in general practice. In 2005, GPs reported working an average of 48 hrs/wk (males worked 56 hrs/wk and females 39 hrs/wk). The 2008 survey showed that the average hours decreased by six hours to 42 hrs/wk (males worked 52 hrs/wk and females worked 33 hrs/wk).

Previous surveys reported that many GPs were concerned about 'burning-out' due to the heavy workload (Pande, 2008). The NZMA (2004) noted that the increase in hours worked will have an impact on work/life balance aspirations and is likely to act as a deterrent to doctors entering and staying in general practice. It would seem that out of concern for their health, some GPs might have reduced their hours. The 2008 survey showed that GPs in all age categories reduced their hours by an average of five to six hours since 2005.

As the GP workforce ages, many older GPs are likely to reduce their hours due to ill health or semi-retirement (Pande & Stenson, 2008; RNZCGP 2005 Membership Survey Report Part II, 2006; RNZCGP 2007 Membership Survey Report Part II, 2009). Many younger female GPs are also reducing their hours to raise families.

In the 2008 survey, while GPs reduced their hours, they actually increased the percentage of time spent on patient consultations. This is mainly due to reducing hours spent on on-call duties, practice administration, and professional development. The College published an occasional paper, *Forecasting GP Workforce Capacity* (RNZCGP, 2006), that addressed some of the issues discussed above, and modelled different possible scenarios to establish an acceptable level of GP to population ratio. This paper puts the capacity of the provider, i.e. the GP, at the centre of the model, in the light of what care they are capable of providing given their strengths and the expectations of the public.

6. Conclusion

This report is based on data gathered by the College as part of its membership survey and looks at the GP workforce. It follows a new format that consolidates the key features of the previous 'three-report' series. There is greater emphasis on gender- and age-based data and the examination of emerging trends since the RNZCGP Workforce Series was started in 2005.

This research needs to be examined 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. The survey reinforces the findings of previous reports that the GP workforce is:

- stressed and diminishing;
- ageing faster than it is being replenished;
- heavily reliant on IMGs; and
- increasingly affected by GPs working fewer hours and getting involved in other activities.

In 2009, the College will train 120 registrars in general practice. Since the Clinical Training Agency (CTA) increased the number of training places in 2008, the College has withdrawn the alternative 'seminar-only'[6] option for GP training. The 'seminar' programme was preferred by male IMG registrars. There is a possibility that GP training places could be further increased in the near future. With only a limited number of medical graduates, and the competition for registrars from other medical specialties, recruitment into general practice training could be challenging. This increase in GP training places will provide a much needed boost to the GP workforce. However, much work is still needed to increase the number of Maori and Pasifika GPs in the workforce.

Constructive action is still needed to ensure:

1. that New Zealand remains an attractive primary health care environment in order to retain New Zealand GPs and attract IMGs.
2. further research to examine trends towards GPs attaining a better work/life balance.
3. further research to examine trends towards GPs' choice of work such as self-employment, and the changes to the small business model.
4. efficient and effective strategic workforce planning by consolidating and standardising national workforce data to improve timeliness, accuracy and comparability.

[6] The 'seminar-only' programme was designed to train those doctors who wanted to do general practice training but could not be accommodated through the CTA-funded places. 'Seminar-only' registrars did not have regular contact with dedicated teachers as did their CTA-funded counterparts. This programme was the 'second-best' option as there was a greater demand for GP training than there were funded training places.

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