



The Royal New Zealand  
College of General Practitioners

# 2014 RNZCGP Workforce Survey



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**The Royal New Zealand  
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# 1 Executive summary

The 2014 workforce survey provides the Royal New Zealand College of General Practitioners (the College), Government and other sector stakeholders with a strong knowledge base that will help to inform future decisions about general practice in New Zealand.

The results of the survey confirm and reinforce some of our existing knowledge. We were already aware that the size of the general practice workforce has not increased sufficiently to meet the demands of our population, and that the number of full-time equivalent GPs per head of population has been decreasing.

The GP workforce is ageing, with the average male GP aged 53.6 years, and we are aware that there are considerably fewer GPs in the cohort aged 35-50 than in the cohort aged 50 to 65. Thirty-six percent of GPs who responded indicated that they intend to retire some time in the next 10 years.

The large cohort of older GPs has considerable skill, knowledge and expertise. If we are to train sufficient new GPs, then we are going to have to draw heavily on that cohort as teachers, mentors and role-models. One of the College's aims in coming months will be to ensure that this cohort is supported and encouraged to continue in the workforce for as long as they are willing and able.

The survey sends some clear messages about the changing face of general practice. While older GPs are predominantly male, younger GPs are predominantly female. The survey confirms that while both Māori and Pasifika doctors continue to be underrepresented among respondents, numbers are trending upwards. The majority of GPs are working as employees or contractors, rather than practice owners or practice partners. The implications for patients and general practice of these changes are not yet clear, but we need to fully understand them as a matter of urgency given the ageing GP population.

A total of 42% of respondents obtained their primary medical degree in another country. Of these doctors, 43% came from the United Kingdom. South African (13%), Indian (9%) and Australian (6%) doctors were also well represented.

The survey also reveals significant regional differences in New Zealand. Some regions contain more older GPs, and more GPs who intend to retire in the near future. There is also considerable variation in terms of age, gender and hours worked across the regions. This information will be of interest to planners in those regions.

The workforce survey also gathered information about GP income. The analysis shows that higher levels of income are, as could be expected, associated with working longer hours and practice ownership.

The College would like to thank the more than 2500 GPs who responded to the survey and we look forward to working with GPs and the sector in using the survey information. The results will help us inform important funding and planning decisions and ensure that in the future, New Zealanders will be able to access high-quality care from their own GP when they need that care.

## 2 Introduction

New Zealand requires appropriate GP workforce levels to ensure adequate service provision, and to enable safe, high quality primary health care. In recent years, the results of the Medical Council of New Zealand's (Medical Council) annual workforce surveys have shown that the GP workforce is ageing and is also shrinking in size relative to the general population. However, while the Medical Council's data provides valuable and authoritative information on the whole medical workforce, it does not provide all the information required to have a full understanding of the general practice workforce. In particular, the Medical Council data does not provide information about GPs' retirement intentions, rurality, income, employment status or their involvement in teaching.

The 2014 College of General Practitioners workforce survey fills many of these gaps, and provides the College, Government and other sector stakeholders with a strong knowledge base that will help inform future decisions about general practice in New Zealand. It provides data about workforce gaps and shortages, as well as information that can help inform decisions on how to address those gaps.

## 3 Discussion

The results of the College's survey confirm and reinforce some existing knowledge. There was already an awareness that the size of the general practice workforce has not increased sufficiently to meet population demands, and in fact the number of full-time equivalent (FTE) GPs per head of population has been decreasing. In 1999 there were 84 FTE GPs per 100,000 New Zealanders. This had fallen to 74 per 100,000 in 2012<sup>1</sup>. By comparison, the ratio in Australia in 2012 was 111.8 FTE GPs per 100,000<sup>2</sup>.

New Zealand has a shortage of general practitioners. In addition to the low and falling FTE GP to population ratio, further evidence can be seen in the existence of waiting lists for patients wishing to enrol with a practice, and practices with closed books. It is known that some regions within New Zealand struggle to attract GPs, and in these locations vacancies remain unfilled for extended periods. The College's survey provides further information and analysis of the current situation.

The survey also shows the GP workforce is ageing, with the average male GP aged 53.6 years, and there are considerably fewer GPs in the cohort aged 35-50 than in the cohort aged 50-65.

The figures around age support those already published by the Medical Council. Their survey results demonstrate that in 2012, 54.8% of GPs were aged 50 or over. Some of the Medical Council's historical data also provides a telling comparison. Data from 1998 showed that only 25.3% of GPs were aged 50 or over.

The ageing of the GP workforce is a particular concern when considered alongside the low levels of GP recruitment in recent years to match the growth of the wider population. Additionally the survey shows us that GPs also tend to work fewer hours than they did in the past.

We also know that future demand for primary care is going to increase as a result of the increase in chronic disease due to population ageing and unhealthy lifestyle choices, a desire to shift services from secondary to primary care, and increasing patient expectations.

It is possible that the impact of the increase in demand may be partially, but not completely, mitigated by other factors including a move to greater self-management by patients, better use of technology, and a shift of some services to other practitioners, such as nurses.

Overall, however, the picture is one of increasing demand for GP services as part of the broader general practice team.

The College, and the sector as a whole, has already begun to respond to these concerns. With funding assistance from Health Workforce New Zealand (HWNZ), the College has been able to increase the number of training places available to new GPs. In 2007, 69 new trainees entered the general practice training programme – in 2014/15 there will be 172, with the expectation that even more new trainees will enter the programme in coming years.

As well as receiving additional funding from HWNZ, the two organisations have been working together to ensure that general practice is seen as an attractive career option for new graduates. General practice was a popular career choice among medical school graduates in the 1980s, when most of those now aged in their 50s graduated. Since then, there has been a marked decline in the proportion of medical school graduates choosing to enter general practice, with the majority of graduates instead choosing secondary care specialties. Between 1998 and 2012, the New Zealand population increased by 17%<sup>3</sup>. During that same period, Medical Council workforce survey results reveal that GP numbers increased by only 13.8% (435), while hospital specialist numbers increased by 68.6% (1739).

The large cohort of GPs currently in the 50-65 age bracket has considerable skill, knowledge and expertise. In order to appropriately train sufficient new GPs, there is going to be a significant reliance on this cohort as teachers, mentors and role-models. One of the College's aims in the coming months

1 Data from the annual Medical Council workforce surveys.

2 *Medical Workforce report 2012*. Australian Institute of Health and Welfare.

3 New Zealand Census 2013. Statistics New Zealand.

will be to ensure that this cohort is supported and encouraged to continue in the workforce as long as they are willing and able.

The College also needs to look at ways to make teaching more attractive to more GPs. Currently 34% of GPs have some involvement in teaching, and more needs to be done in order to help the new generation of registrars to develop into competent and confident GPs.

A total of 42% of respondents obtained their primary medical degree in another country. GPs from Commonwealth, and former Commonwealth, countries are well represented with a significantly high proportion from the UK (43%), followed by South Africa (13%), India (9%) and Australia (6%). The survey also sends us some clear messages about the changing face of general practice. While older GPs are predominantly male, younger GPs are predominantly female. These younger female GPs are more likely to work part-time and as employees, and it is unclear whether they will continue working part-time in future years or look to increase their hours either as employees or practice owners.

The survey also confirms that while both Māori and Pasifika doctors continue to be underrepresented among respondents, numbers are trending upwards. However, the GP population is still a long way from being representative of the general population.

Furthermore, the survey reveals significant regional differences in New Zealand. Some regions contain more older GPs and more GPs who intend to retire in the near future. There is also considerable variation in terms of age, gender and hours worked across the regions. This information will be of considerable interest to planners in those regions.

The workforce survey also contains new information about GP income. Research in other parts of the world tells us that secondary care specialists tend to earn more than GPs, and this may be a factor in the major shift in medical graduate career preferences over recent years<sup>4</sup>.

While income should not be the most significant factor in choosing a career in medicine, or in general practice, the evidence suggests that expected future earnings do influence specialty choice<sup>5</sup>. It is therefore important to have accurate information on income both to present to policy makers and to medical graduates.

The analysis of the GP-specific income data collected as part of this survey shows that within general practice it appears that higher levels of income are associated, as could be expected, with working longer hours and practice ownership. However, there also appears to be an association with male gender, although this needs further exploration.

There have been a range of learnings from the process of conducting the 2014 survey. In future years the College will build on this experience and continue to improve the structure and content of the survey, to make it easier for GPs to answer and to ensure that we obtain information more efficiently.

Some questions will be removed, and there are plans to include new questions, targeted to provide the College better information about the areas of concern identified in this survey.

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4 Dr Anthony Scott. Getting the balance right between generalism and specialisation: Does remuneration matter? *Australian Family Physician*. Vol 43;4, April 2014. Pages 229-232.

5 Ibid.

## 4 Data collection and response rate

The survey was conducted in March and April 2014. All 4514 Fellows, Members and Associates of the College, and the Division of Rural Hospital doctors, were invited to participate, and 2525 responses were received, a response rate of 55.9%. The College database, which includes the vast majority of doctors working in New Zealand general practice, was used to identify and contact survey recipients. In New Zealand, doctors are legally able to work in general practice without the additional training required for vocational (specialist) registration, and these non-vocationally registered doctors may not be included in the College database. An increasing proportion of the primary care workforce is made up of vocationally registered general practitioners, while the number and proportion of those who have not undertaken or completed vocational training in general practice is decreasing. As at March 2014, there were approximately 600 non-specialists practising in primary care, 14% of the workforce.

We received only 31 responses from doctors who indicated that they were not vocationally registered or training towards vocational registration in the scopes of general practice or rural hospital medicine. Hence the results of the survey are not able to be generalised to this group.

A comparison of the age profile of respondents (see Section 5.1) with the age profile of eligible doctors, as recorded in the College database has shown that the age profiles are comparable. There was a slight overrepresentation of females among respondents as only 47% of eligible doctors were female but 51% of all respondents were. (Note this 51% includes doctors currently not working in New Zealand, so it differs from the percentage of working respondents who were female).

Survey recipients included doctors who are retired, currently out of the workforce, working in other careers, or working overseas. Unless otherwise specified, the data in this report refers to the 2215 respondents who stated that they were currently working in New Zealand in either general practice or rural hospital medicine. These doctors made up 88% of all respondents.

All data in this report is presented un-weighted. Not all questions were compulsory and the survey was structured so that respondents were not asked questions that were not relevant to them. The totals in the tables that follow differ according to the number of doctors who responded to the relevant question.

The survey design meant that it was not possible to differentiate between GPs and rural hospital doctors, therefore results for both these groups are presented together. Future surveys will make this distinction.

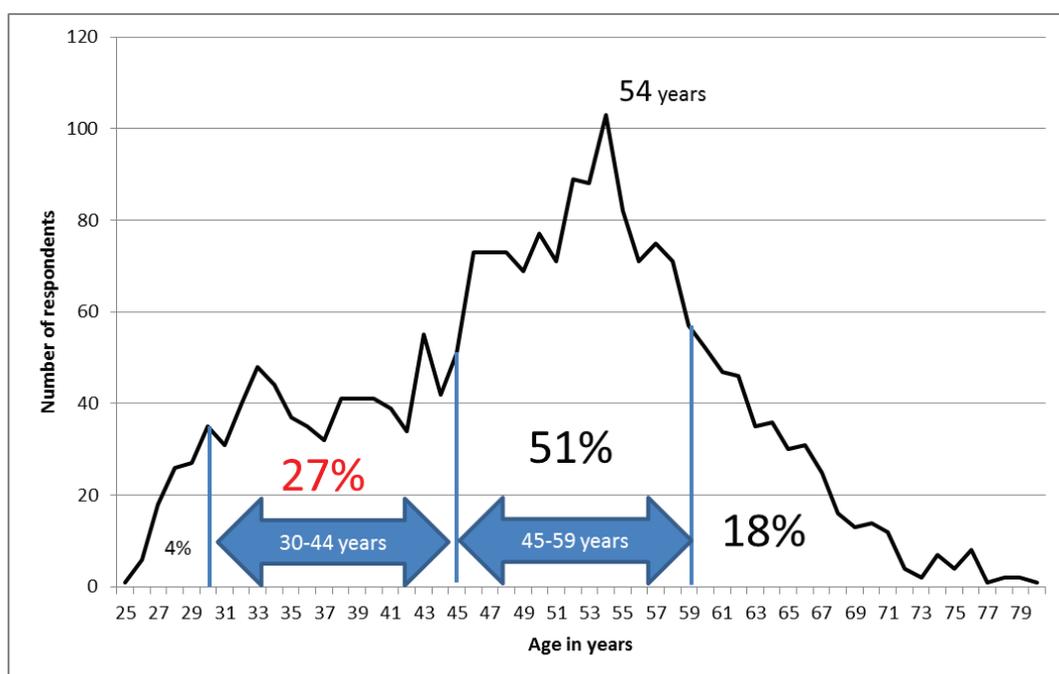
## 5 Workforce demographics

### 5.1 Age and gender

The age and the gender profiles of New Zealand's GP workforce are known to be unusual, with a concentration of GPs in their 50s followed by much smaller numbers in their 30s and 40s. The survey results are consistent with this.

As illustrated by Figure 1, the 15 year interval from 45-59 years contains 51% of all working respondents whereas only 27% of respondents were aged within the fifteen year interval of 30-44 years. A surprising 18% of working respondents were aged 60 or over, and the remaining 4% of respondents were aged under 30. The largest numbers of respondents were aged 54. In total, 54% of working respondents were aged 50 years and over.

Figure 1: Age profile of respondents



The data around age is consistent with results already published by the Medical Council. Its survey results demonstrate that in 2012, 54.8% of GPs were aged 50 or over. Some of the Medical Council's historical data also provides a telling comparison. In 1998 only 25.3% of GPs were aged 50 or over and the largest number of GPs was aged 39.

Over recent years the number of younger GPs has started to increase slightly, and this has made the very low numbers currently in their late 30s and early 40s more apparent in the age profile. As the GPs in the older bulge retire, this will unmask the insufficient numbers in the younger age cohort that follows it.

General practice was a popular career choice among medical school graduates in the 1980s when most of those doctors now in their 50s graduated. Since then, there has been a marked decline in the proportion of medical school graduates choosing to enter general practice, with the majority of graduates choosing secondary care specialties instead. Between 1998 and 2012, the New Zealand population increased by 17%. During that same period, Medical Council surveys reveal that GP numbers increased by only 13.8% (435), while hospital specialist numbers increased by 68.6% (1739).

Just over half of survey respondents (52%) were female, a slightly higher proportion than expected. By comparison the 2012 Medical Council workforce survey recorded 46% of GPs as female.

The proportion of female medical graduates has increased over the years<sup>6</sup>, and with it the proportion of female GPs. In 1980, for example, only 13% of New Zealand GPs were female<sup>7</sup>. Figure 2 illustrates the effect that this increase in the number of females over time has had on the gender balance within successive age cohorts. Respondents younger than 50 were more likely to be female, and those older than 55 more likely to be male, with differences becoming even more noticeable at each end of the age spectrum.

Figure 2: Gender of respondents by age

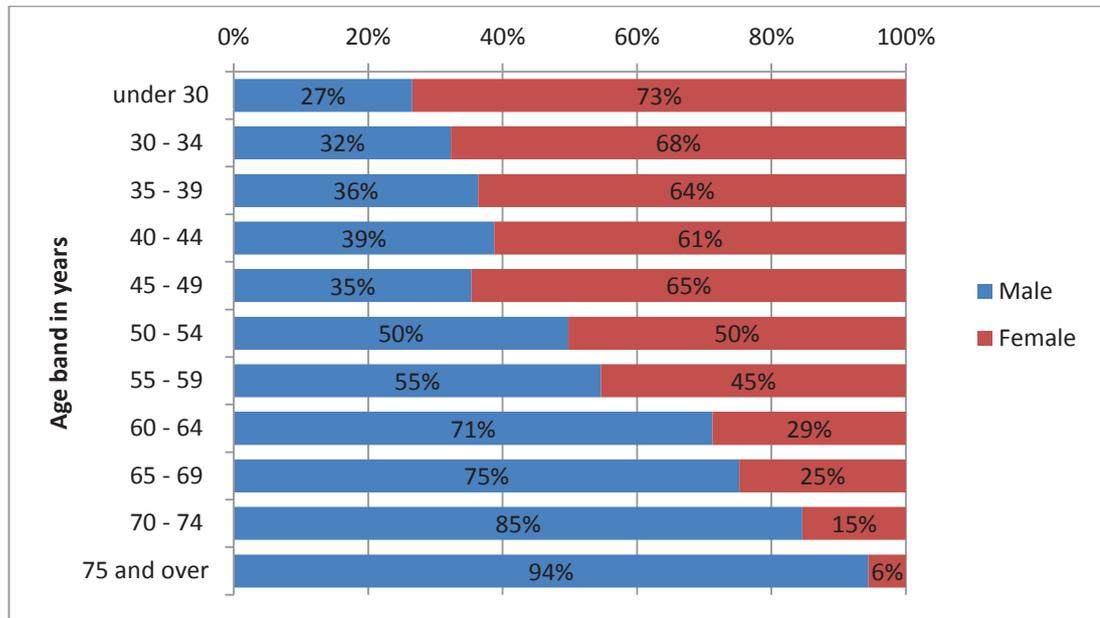


Table 1 shows the total number of survey respondents by age and gender. There were 31 respondents who did not provide their gender and are therefore not recorded in this table.

Table 1: Age and gender of respondents

	Female		Male		Total #
	#	%	#	%	
Under 30	58	73.4	21	26.6	79
30-34	134	67.7	64	32.3	198
35-39	119	63.6	68	36.4	187
40-44	128	61.2	81	38.8	209
45-49	219	64.6	120	35.4	339
50-54	214	50.2	212	49.8	426
55-59	162	45.4	195	54.6	357
60-64	63	28.8	156	71.2	219
65-69	28	24.8	85	75.2	113
70-74	6	15.4	33	84.6	39
75 and over	1	5.6	17	94.4	18
<b>Total</b>	<b>1132</b>	<b>52</b>	<b>1052</b>	<b>48</b>	<b>2184</b>

6 MCNZ workforce surveys

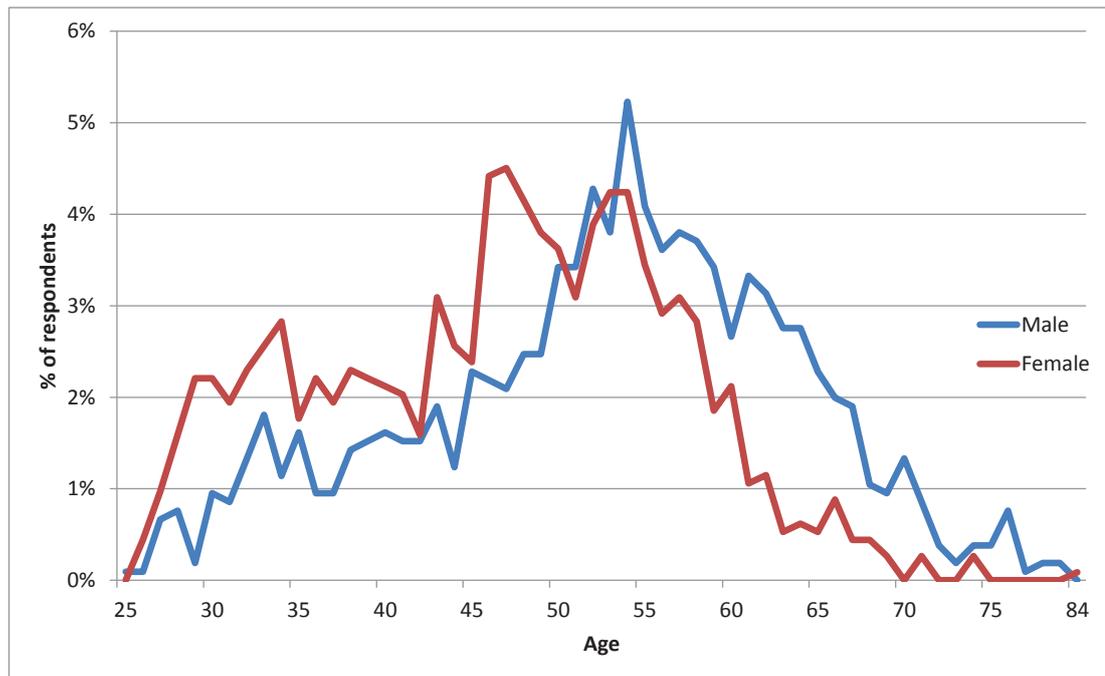
7 New Zealand Medical Manpower Statistics 1980. Department of Health Blue Book Series 1982.

The average age of respondents was 50 years, with the average age of female respondents being 46.7 years, and the average age of male respondents being 53.6 years.

It is an interesting reflection of the magnitude of the transformation from a predominantly male GP workforce to an increasingly female workforce, to note that the number of males still remaining in the 65-69 cohort (85) significantly exceeds the number of males in both the 30-34 year cohort (64) and the 35-39 year cohort (68).

The difference in age profiles between male and female respondents can be seen in Figure 3.

**Figure 3: Age profile by gender**



## 5.2 International medical graduates

International medical graduate (IMG) is the term that describes doctors who gained their primary medical qualification in a country other than where they are currently working.

A total of 927 survey respondents (42%) were IMGs. This is comparable to the findings of the Medical Council 2012 survey which reported that 43.7% of New Zealand GPs were IMGs. At 41.9%, the proportion was also high amongst hospital specialists.

Overall the Medical Council 2012 survey found that 41.4% of New Zealand doctors were IMGs. New Zealand's reliance on IMGs is known to be a particular concern, with the OECD reporting that New Zealand had the highest proportion of migrant doctors among OECD countries.<sup>8</sup> Australia is another country with a high reliance on IMGs, and in 2013 33% of all doctors in Australia were IMGs.

Those respondents who stated that they were IMGs were asked to name the country where they gained their primary medical qualification (see Table 2). The United Kingdom was the most commonly mentioned, with 43% of IMGs having gained their primary medical qualification there. Of interest, 80% of IMGs have come from Commonwealth countries, primarily the United Kingdom and South Africa.

<sup>8</sup> **Health workforce and international migration: can New Zealand compete?** Pascal Zurn and Jean-Christophe Dumont. OECD Health working paper 33 (2008).

**Table 2: IMGs by country of primary medical qualification**

Country of graduation	#	%
United Kingdom	377	43
South Africa	114	13
India	78	9
Other <sup>9</sup>	78	9
Australia	57	6
Sri Lanka	29	3
Germany	24	3
Iraq	23	3
Bangladesh	18	2
China	18	2
Ireland	16	2
Canada	12	1
USA	12	1
Pakistan	9	1
Philippines	7	1
Russia	7	1
Zimbabwe	7	1
<b>Total</b>	<b>886</b>	<b>100</b>

### 5.3 Rural and urban respondents

There is currently no universally accepted definition of rural general practice. In this survey we asked respondents to self-identify the practice where they worked as either:

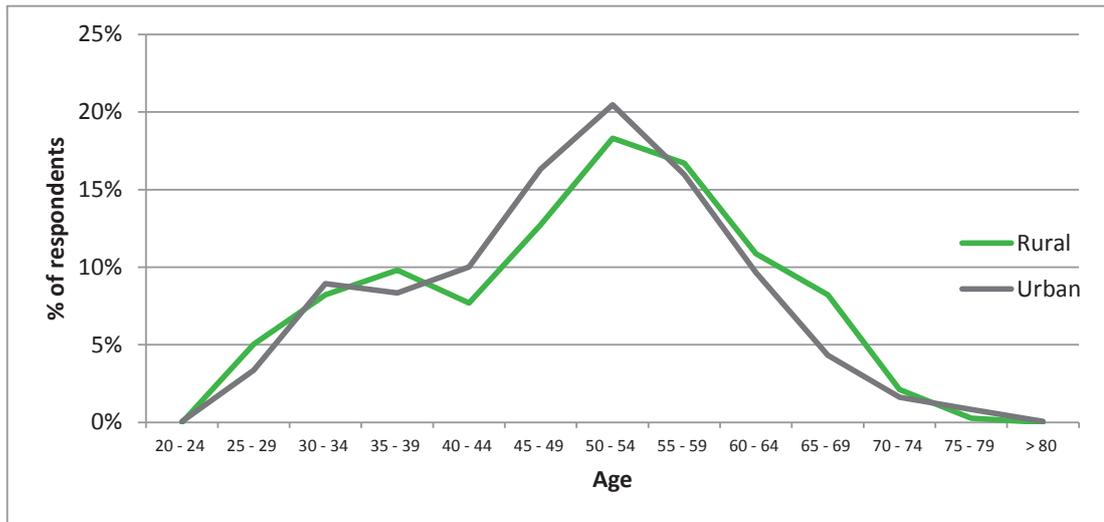
- urban;
- rural; or
- not clearly rural or urban.

Three-quarters (75.2%) of respondents (1,666) considered that they worked in an urban practice, 17% (377) considered that they worked in a rural practice, and 7% (160) considered their practice not clearly rural or urban. Twelve respondents did not classify their practice.

Figure 4 compares the age profiles of the rural and urban groups.

<sup>9</sup> Countries in the 'Other' category were Belgium, Brazil, Bulgaria, Burma, Colombia, Croatia, Cuba, Denmark, Egypt, Fiji, Hungary, Israel, Italy, Japan, Netherlands, Nigeria, Norway, Papua New Guinea, Peru, Poland, Romania, Serbia, Singapore, South Korea, Spain, Sweden, Switzerland, Syria, Taiwan, Tanzania, Uruguay.

Figure 4: Rural/urban age profile



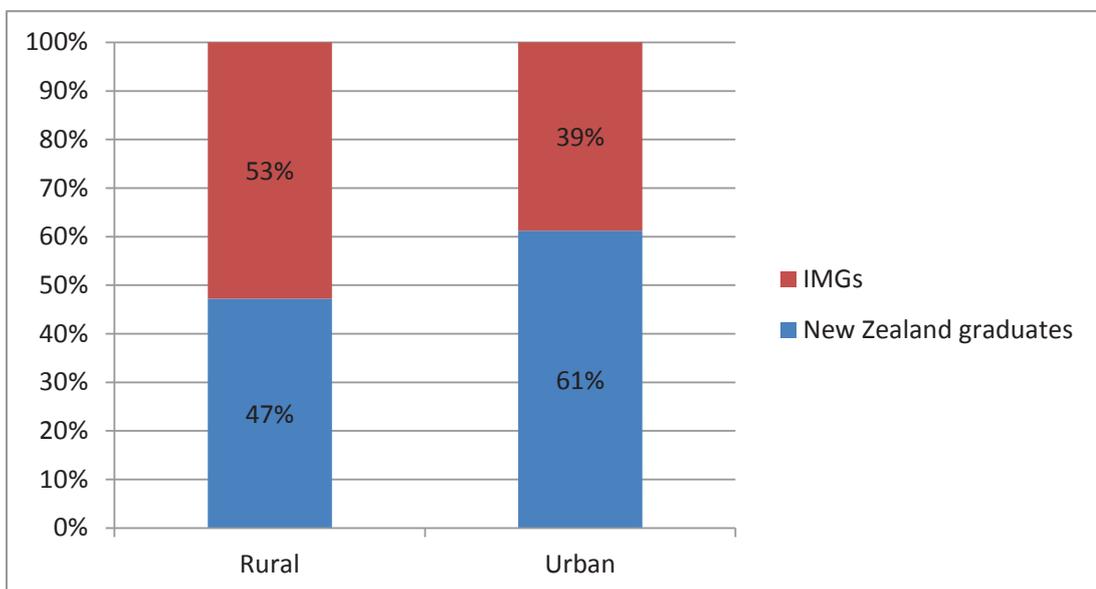
Rural respondents tended to be slightly older with 37% over the age of 55 years compared with 33% of urban respondents. Respondents who classified their practices as rural were also more likely to be male (57%) compared to urban respondents (46%).

As mentioned in Section 5.2, 42% of all respondents were IMGs. Our survey results show that New Zealand's reliance on IMGs is particularly marked within the rural workforce. As shown in Table 3 and Figure 5, more than half (53%) of respondents from rural practices were IMGs. This compares with only 39% of respondents from urban practices.

Table 3: Comparison of the proportion of IMGs among rural and urban respondents

	Rural		Urban	
	#	%	#	%
New Zealand graduates	178	47	1020	61
IMGs	199	53	646	39

Figure 5: Comparison of the proportion of IMGs among rural and urban respondents

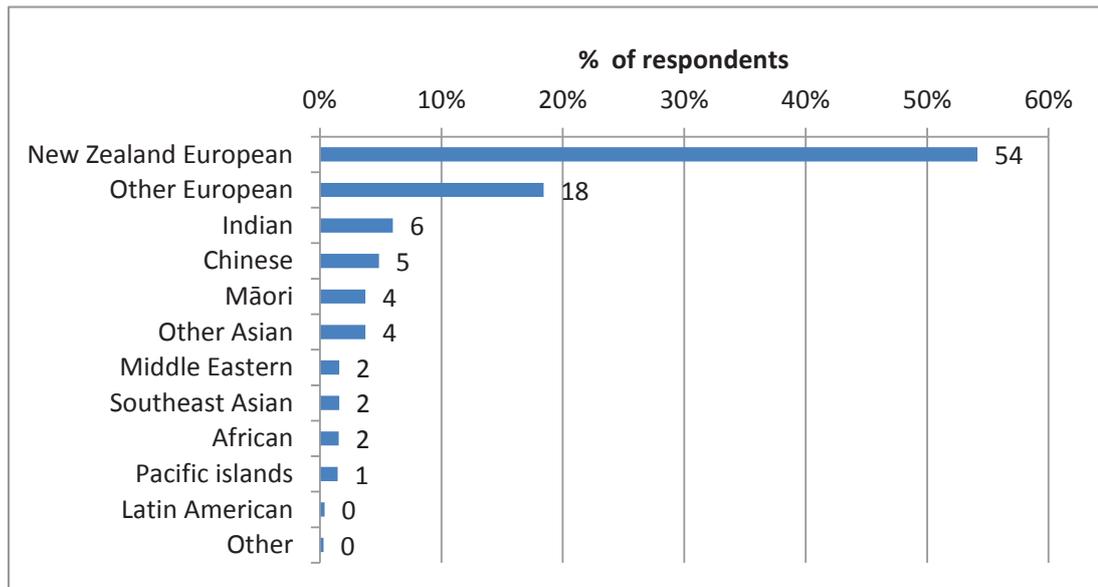


IMGs who gained their primary medical qualification in the United Kingdom or South Africa comprise of 50% and 17% respectively of all rural IMGs, again reflecting the importance of IMGs from Commonwealth countries.

## 5.4 Ethnicity

As illustrated in Figure 6, the majority of doctors identified as European, with a total of 72.6% identifying as either 'New Zealand European' or 'Other European'. Only 3.8% of respondents (85) identified as Māori and just 1.5% (33) identified as Pacific. This compares with 2012 Medical Council data showing that 2.9% of GPs identified as Māori and 1.6% as Pacific.

Figure 6: Ethnicity of respondents



The 2013 Census data in Table 4 shows that 15% and 7% of the New Zealand population identify as Māori and Pacific respectively.<sup>10</sup>

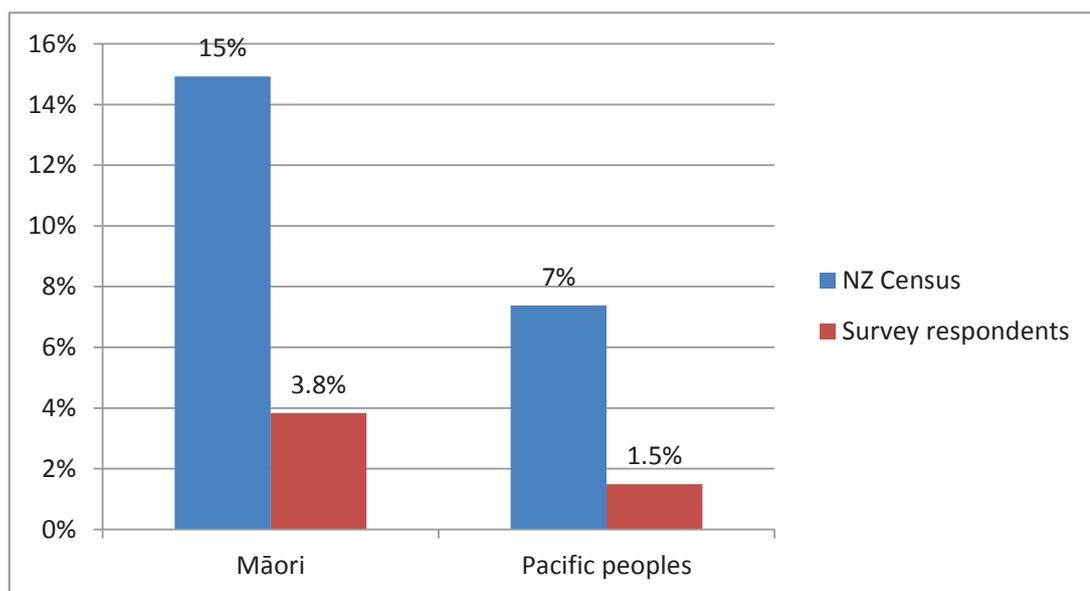
Table 4: Grouped total ethnicity responses from New Zealand Census 2013

	Number	%
European	2,969,394	74
Māori	598,605	15
Pacific peoples	295,941	7
Asian	471,708	12
Middle Eastern/Latin American/African	46,956	1
Other ethnicity	67,752	2
<b>Total people stated</b>	<b>4,011,402</b>	<b>100</b>

The proportion of doctors identifying as Māori or Pacific in this survey was considerably lower than the population proportions, and this is illustrated by Figure 7.

<sup>10</sup> New Zealand Census, 2013. Statistics New Zealand.

Figure 7: Comparison of population and respondents' ethnicity for Māori and Pacific



In recent years there have been initiatives aimed at increasing the number of Māori and Pacific people entering New Zealand medical schools. These initiatives may be having an effect. Table 5 shows that for respondents under the age of 40, the proportion of those who identify as Māori more than doubles from 3.8% to 8.5%. The proportion identifying as Pacific also increases from 1.5% to 2.8%.

This suggests that, over time, the proportion of Māori and Pacific GPs will increase. However, as the proportion of Māori and Pacific among younger respondents remains lower than that in the population, unless the proportion of young Māori and Pacific GPs increases further, time alone will not produce a workforce that more accurately reflects the composition of New Zealand society.

Table 5: Comparison of the ethnicity of respondents over and under 40 years

	Māori		Pacific		All #
	#	%	#	%	
Under 40 years	40	8.5	13	2.8	471
40 and above	45	2.6	20	1.1	1744
<b>Total</b>	<b>85</b>	<b>3.8</b>	<b>33</b>	<b>1.5</b>	<b>2215</b>

## 6 Working hours

The supply of GPs is determined not only by the number of doctors, but also by the hours worked by each doctor. In recent years there has been a decline in the number of hours worked by doctors in New Zealand, including by both GPs and hospital specialists. This decline in hours worked has also been observed internationally. Fewer doctors are working the long hours that are neither good for their own health, nor the safety of their patients and there has also been an increase in the number of doctors choosing to work part-time. Medical Council survey data reveals that younger GPs are increasingly working part-time.

In 1998, 61% of 35-39 year old GPs were working at least 40 hours per week. By 2012, this proportion had almost halved to 33%. Some of this difference may be attributable to the rise in the number of females in the workforce, as female GPs are more likely to work part-time than male GPs. In 1998, females made up 35% of the GP workforce as opposed to 46% in 2012.

Medical Council surveys reveal that between 1998 and 2012 GP numbers increased by 435, a 13.8% rise. However, the increase in GP full-time equivalents (FTEs) over this same time was only 4%, less than a third of the increase in headcount. The hours worked by GPs fell from an average of 38 per week in 1998 to 35 in 2012.

The net result of the changes in working hours and the minimal increase in the number of GP FTEs has been a concerning decrease in the ratio of GP FTEs per head of population from 83 FTE GPs per 100,000 population in 1998 to 74 FTE GPs per 100,000 population in 2012. The decline in average hours worked has played a major part in the overall decline in the availability of GP services.

Because of the importance of hours worked to the supply of GP services, this survey included several questions regarding current working hours as well as future intentions regarding working hours.

Respondents were asked to select the appropriate range of hours they worked per week from 11 options. When determining this, respondents were instructed to include on-call time that is actually worked as well as time spent on patient-related activities such as paperwork.

For the purposes of this survey, those respondents working less than 36 hours per week have been deemed to be working part-time. The majority of respondents (54%) worked 36 or more hours per week, with the remaining 46% working part-time. As shown by Figure 8 and Table 6, the majority (63%) of those working full-time were male and the majority (69%) of those working part-time were female.

**Figure 8: Male and female respondents and hours worked**

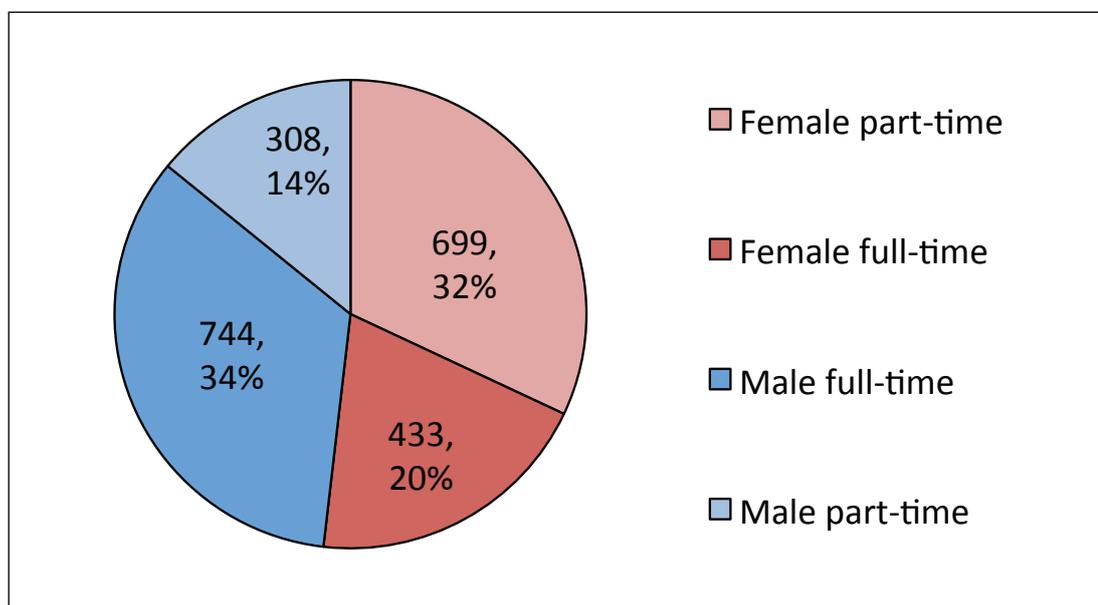


Table 6 breaks the distribution of working hours down further, revealing that:

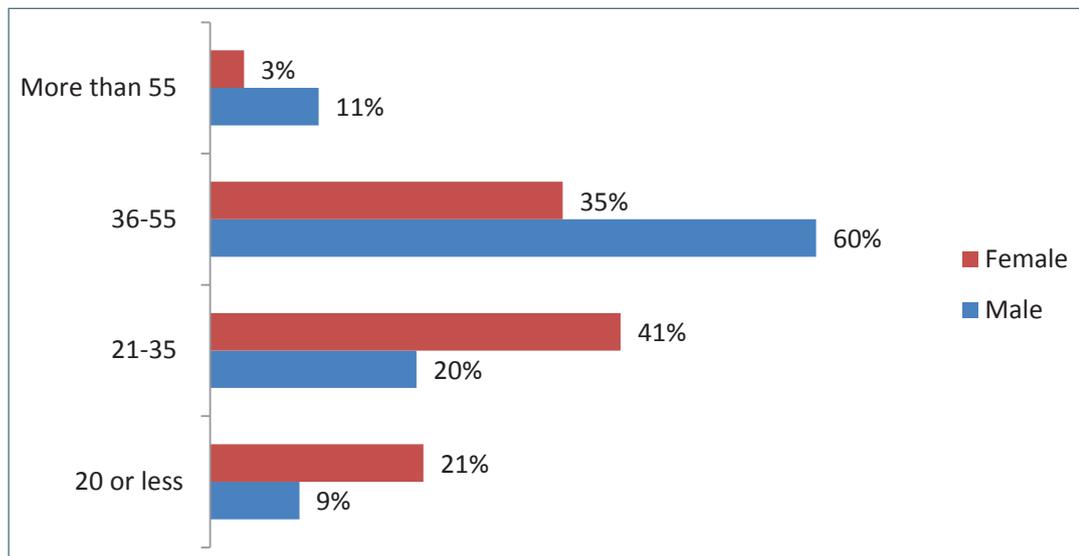
- 15% of respondents worked 20 hours per week or less;
- 31% worked 21-35 hours per week;
- the majority, 47%, worked 36-55 hours per week; and
- 7% of working respondents worked more than 55 hours per week.

**Table 6: Working hours per week (hpw) by gender**

Hours per week	Female		Male		Total	
	#	%	#	%	#	%
20 or less	239	21	93	9	340	15
21-35	460	41	215	20	686	31
36-55	395	35	631	60	1036	47
More than 55	38	3	113	11	153	7
<b>Total</b>	<b>1132</b>	<b>100</b>	<b>1052</b>	<b>100</b>	<b>2215</b>	<b>100</b>

Table 6, and Figures 8 and 9, illustrate that female respondents were more than twice as likely as male respondents to work part-time, with 62% of female respondents working less than 36 hours per week compared to 29% of male respondents. The majority (71 %) of male respondents worked full-time, compared with 38% of females.

**Figure 9: Distribution of working hours by gender (hours per week)**



## 6.1 Median working hours

The median working hours range for all (working) respondents was 36-40 hours per week with the median for females in the 31-35 hours per week band, and for males in the 36-40 hours per week band.

By taking the midpoints of each of the 11 working hour ranges, it was possible to estimate an average number of hours worked. It should be noted that as the distribution of hours within each range may be skewed rather than centred on the midpoint, this estimate may not reflect the true average. Using this method, the average working hours were estimated to be 31.2 hours per week for females and 39.8 hours for males.

The estimated average working hours per week for all (working) respondents was 35.3 hours.

## 6.2 Working hours and employment status

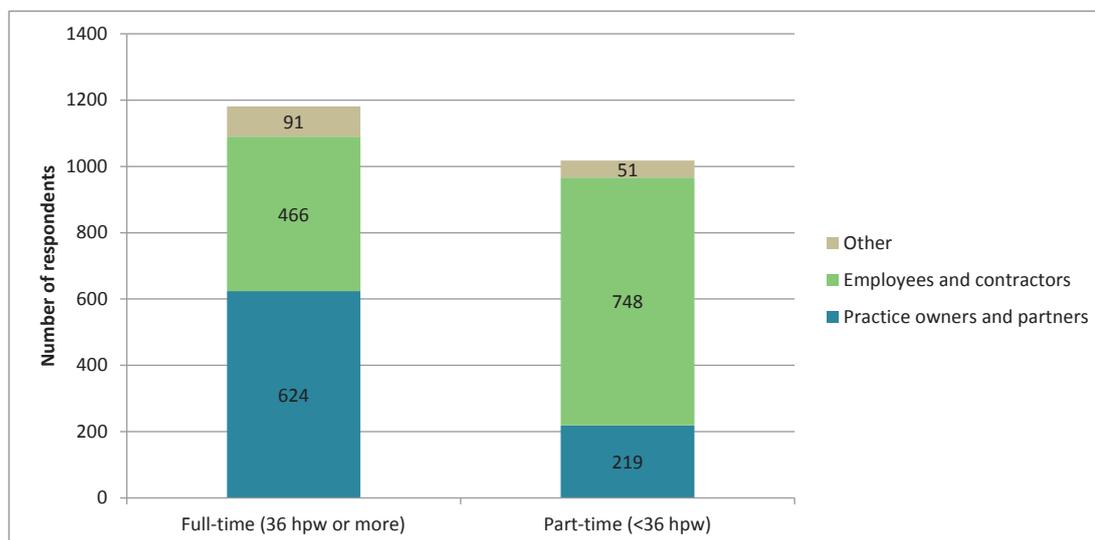
Table 7 compares the hours worked per week by respondents in different employment situations. (Employment arrangements for general practitioners vary and are discussed further in Section 8.1.) Those working the most hours per week were practice owners and partners. Overall, the majority of practice owners (77%) and practice partners (71%) worked 36 or more hours per week. Employees and contractors were more likely to work part-time, with only 39% of long-term and 33% of short-term employees/contractors working more than 36 hours per week.

*Table 7: Working hours by employment status*

Hours worked per week	Practice owner		Practice partner		Long-term employee/contractor		Short-term employee/contractor e.g. locum		Other	
	#	%	#	%	#	%	#	%	#	%
Over 55	75	16	35	10	33	3	2	1	6	4
36-55	289	61	225	61	367	36	64	32	85	60
21-35	98	21	99	27	382	38	65	32	36	25
20 or less	14	3	8	2	230	23	71	35	15	11
<b>Total</b>	<b>476</b>	<b>100</b>	<b>367</b>	<b>100</b>	<b>1012</b>	<b>100</b>	<b>202</b>	<b>100</b>	<b>142</b>	<b>100</b>

Figure 10 illustrates that the majority of part-time respondents were employees, and that part-time employees made up the largest group of respondents.

*Figure 10: Employment status of full-time and part-time respondents (hours per week - hpw)*



## 6.3 Working hours and rurality

As noted in Section 5.3, 17% of respondents considered that the practice they worked in was rural, 75% identified as urban and a further 7% worked in practices that were not clearly urban or rural. Table 8 compares the hours worked per week by the rural and urban categories. Rural respondents were more likely to work full-time (67%) than respondents in urban practices (50%).

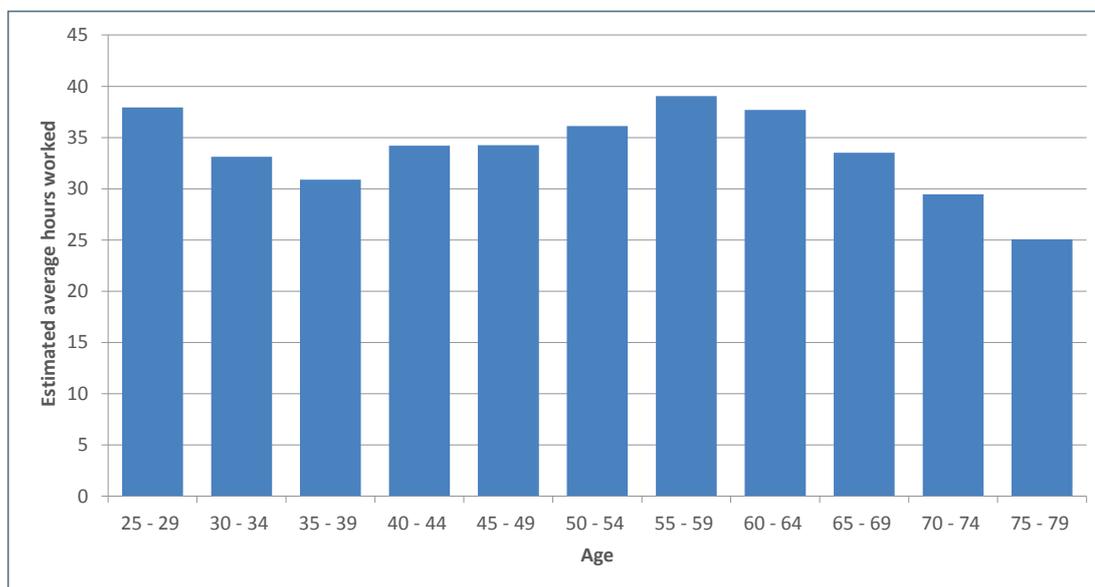
Table 8: Working hours of rural and urban respondents

Hours worked per week	Rural		Urban	
	#	%	#	%
20 or less	37	10	280	17
21-35	88	23	547	33
36-55	212	56	739	44
Over 55	40	11	100	6
<b>Total</b>	<b>377</b>	<b>100</b>	<b>1666</b>	<b>100</b>

## 6.4 Working hours and age

Older doctors make a very significant contribution to the workforce. The survey showed that 55-59 year olds worked, on average, the most hours per week followed by 60-64 year olds and 25-29 year olds. Respondents aged 30-49 worked fewer hours than average, particularly those in the 35-39 age band. Although the average hours worked by respondents in the older age groups fell as their age increased, even those in their late 70s were still making a significant workforce contribution, working on average 25 hours per week. Respondents aged 60 and over made up 18% of all working respondents and were responsible for 18% of the estimated total hours worked. Respondents aged 45-59 years made up 51% of respondents and were responsible for an estimated 53% of hours worked. By comparison respondents aged 30-44 made up 27% of all respondents and were responsible for an estimated 25% of all hours worked.

Figure 11: Working hours by age (estimated average)



If young respondents continue to work similar part-time hours as they age, and as the older predominately male and frequently full-time respondents retire, then New Zealand will need to further increase the number of GPs in order to maintain the ratio of GP FTEs per head of population.

## 6.5 Intended future working hours

Respondents who were still intending to be working in five years' time were asked to indicate whether they intended to be working more, fewer or a similar number of hours per week. The majority of respondents (56%) indicated that they would be working a similar number of hours per week while 32% indicated that they intended to be working fewer hours in five years' time.

This loss to the workforce will be offset somewhat by the 12% of respondents who intended to be working more hours per week in five years' time. Although we have information on the direction of the intended change in hours, participants were not asked about the size of the change so the magnitude of the net loss of working hours cannot be estimated.

The intentions of males and females differed. In five years' time, 18% of females intend to be working more while only 4% of males thought they would. Conversely, 40% of males intended to be working fewer hours per week in five years' time compared to 27% of females. Among those who were intending to increase their hours, 84% were female.

**Table 9: Working intentions of respondents planning to be practising in five years' time by gender**

Working hours per week in five years	Female		Male		Total	
	#	%	#	%	#	%
Similar number	582	55	491	57	1073	55.9
Fewer	282	27	342	40	624	32.5
More	191	18	32	4	223	11.6
<b>Total</b>	<b>1055</b>	<b>100</b>	<b>865</b>	<b>100</b>	<b>1920</b>	<b>100</b>

The 228 respondents who intend to increase their working hours in five years' time were asked to select the reasons that applied to them from four suggested options with multiple answers accepted. The most common reason was 'I expect that childcare will make less demands on my time'. Of these, 92% (168) of respondents choosing this option were female.

**Table 10: Reasons for anticipated increase in working hours**

	#	%
I expect that childcare will make less demands on my time	183	85
I wish to increase my income	94	44
I wish to progress my career	62	29
I will have completed study or other projects	27	13
Other	14	6

Those respondents who intended to decrease their hours of work in five years' time were asked to select as many of the seven suggested reasons that were relevant to them. Of the 621 respondents who answered this question, 59% selected 'I want to improve my work/life balance'. The next most popular reason was 'I want to reduce my work commitments as I move towards retirement', which was selected by 47% of those who responded.

**Table 11: Reasons for anticipated decrease in working hours**

	#	%
I want to improve my work/life balance	367	59
I want to reduce my work commitments as I move towards retirement	294	47
I want to undertake or increase other work in the health sector and will need to reduce my work commitments in general practice or rural hospital medicine	82	13
I want to start a family or have more children	81	13
I want to undertake or increase voluntary work and will need to reduce my work commitments in general practice or rural hospital medicine	61	10
I want to reduce my hours for health reasons	43	7
I want to pursue commercial interests in a non-medical field, and will need to reduce my work commitments in general practice or rural hospital medicine	37	6
Other	30	5

## 7 Retirement

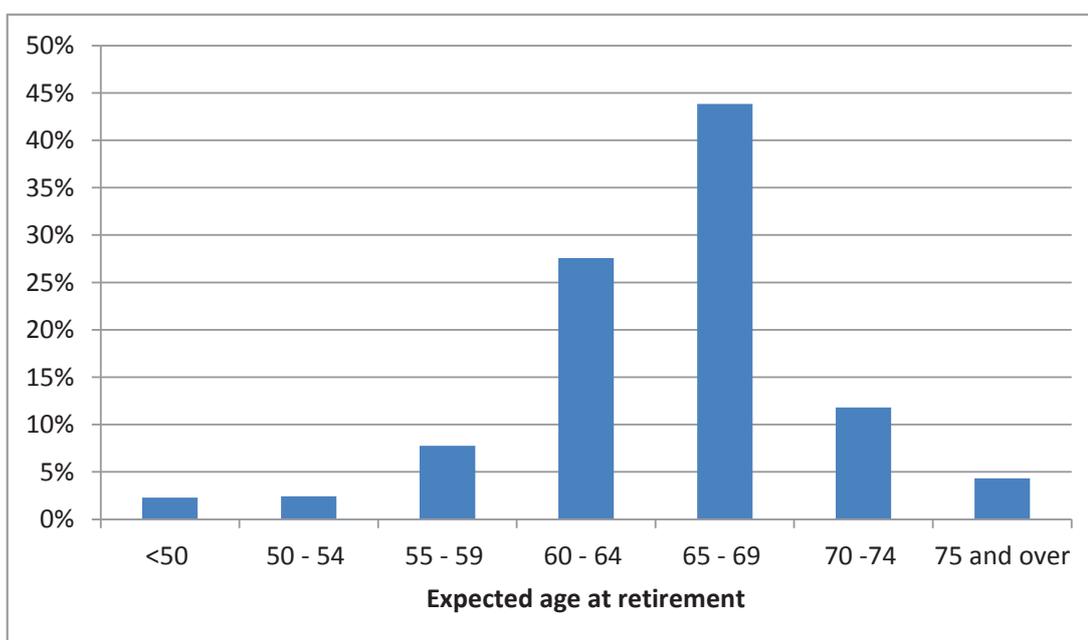
Given the large number of GPs in the older cohorts, information on current retirement practices and future retirement intentions is important in predicting future workforce numbers, and in assessing the number of future trainees that will be required.

Most of the 54 retired GPs who responded to the survey retired relatively late in their careers. Their median age at retirement was 69 years with a range from 42 to 86 years. Eighty-six percent of those who retired before the age of 60 and 58% of those who retired before the age of 65 gave ill health as a reason for retirement.

Currently working survey participants were also asked about retirement. Figure 12 illustrates the distribution of the ages at which they expected to retire. The majority of respondents (88%) indicated that they would expect to be 60 years of age or over at retirement, with 28% expected to retire at between 60 and 64 years of age.

There were 2195 responses to this section.

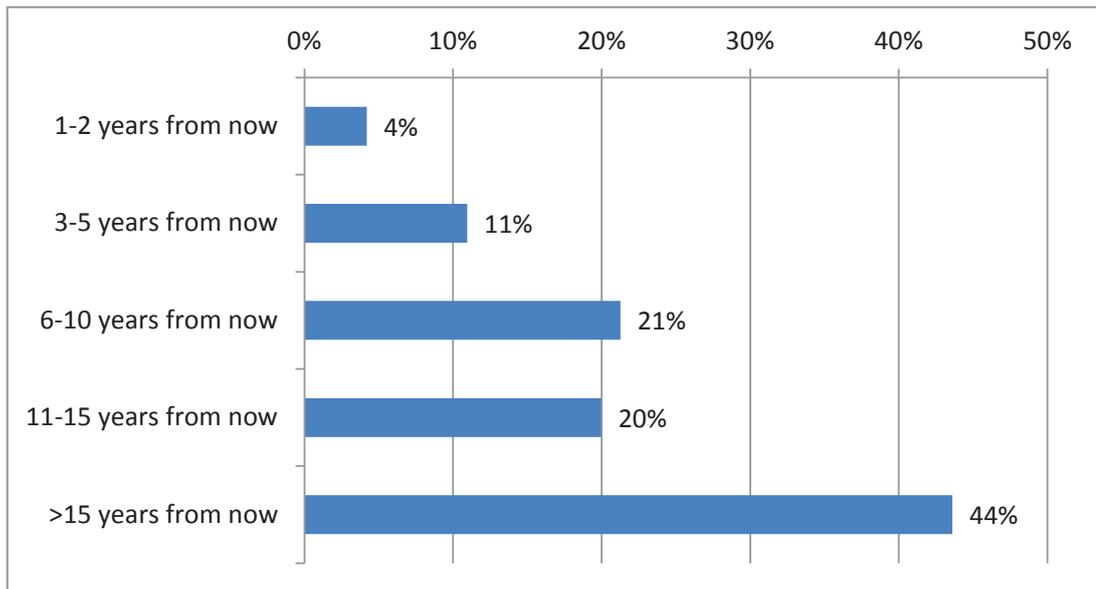
**Figure 12: Expected age at retirement (years)**



Participants were also asked to indicate in how many years from now they intended to retire. As shown in Figure 13, they were asked to select from five ranges. More than a third of respondents (36%) indicated that they were intending to retire in the next 10 years.

Assuming a career length of 40 years, we would usually expect around 25% of the workforce to retire over any ten year interval. In the medical workforce, we would expect the numbers reaching retirement age to be even lower, because comparatively fewer doctors were entering the workforce 40 years ago (180 in the medical school intake of 1974, compared to 338 in 2007).

**Figure 13: Years remaining until intended retirement**



The retirement intention information reinforces the analysis of the age profile data, namely that without action to increase the number of entrants into the GP workforce, the supply of GPs can be expected to fall significantly.

Table 12 includes only those respondents already 50 years of age or over. Within this cohort, the proportion of respondents indicating that they intend to retire in the next 10 years rises to 64%. This cohort of GPs has considerable skill, knowledge and expertise. If we are to train sufficient new GPs, then we are going to need to draw heavily on this group as teachers, mentors and role-models.

**Table 12: Years until intended retirement for respondents aged 50 and over**

Intended retirement - years from now	Respondents aged 50 and over	
	#	%
1-2	88	7
3-5	235	20
6-10	434	37
11-15	316	27
More than 15	111	9

Respondents aged 50 and over were asked 'Which of the following factors might encourage you to remain longer in general practice or rural hospital medicine before retiring?' This question was answered by 686 respondents. The top three responses all related to work/life balance; remuneration was fourth, followed by employment and regulatory issues.

Table 13 compares the retirement intentions of respondents who considered they worked in a rural practice with the intentions of those who considered that they worked in an urban practice. A slightly higher proportion of rural respondents (40%) indicated that they intend to retire within 10 years. For urban respondents, this proportion was 35%. It is worth noting that a higher proportion of rural respondents were aged over 55 years than urban respondents.

Table 13: Years until intended retirement for rural and urban respondents

Intended retirement - years from now	Rural		Urban		Not clearly urban or rural	
	#	%	#	%	#	%
1-2	20	5	64	4	8	5
3-5	46	12	166	10	27	17
6-10	86	23	343	21	37	23
11-15	70	19	346	21	22	14
More than 15	154	41	733	44	66	41
<b>Total</b>	<b>376</b>	<b>100</b>	<b>1652</b>	<b>100</b>	<b>160</b>	<b>100</b>

## 8 Employment status and income

### 8.1 Employment status

Employment arrangements for GPs vary. Survey participants were asked to select their employment status from a list of five options. More than half of respondents (55%) indicated that they were employees or contractors, 39% stated that they were either practice owners or partners and 6% classified their employment status as 'Other'. Many of those who chose 'Other' were registrars.

The 55% who stated that they were employees or contractors comprised 46% who indicated they were long-term employees or contractors and 9% who indicated they were short-term employees or contractors e.g. locums.

The survey indicated that there were more practice owners (22%) than partners (17%). Table 14 compares male and female respondents by employment status.

*Table 14: Respondents by employment status and gender*

	Female		Male		Total	
	#	%	#	%	#	%
Practice owner	155	14	317	30	476	22
Practice partner	155	14	207	20	367	17
Long-term employee/ contractor	624	56	371	35	1012	46
Short-term employee/ contractor, e.g. locum	101	9	96	9	202	9
Other	86	8	56	5	142	6
<b>Total</b>	<b>1121</b>	<b>100</b>	<b>1047</b>	<b>100</b>	<b>2199</b>	<b>100</b>

Figure 14 illustrates that the majority of practice owners and partners were male (63%) and the majority of employees and contractors female (61%).

*Figure 14: Employment status by gender*

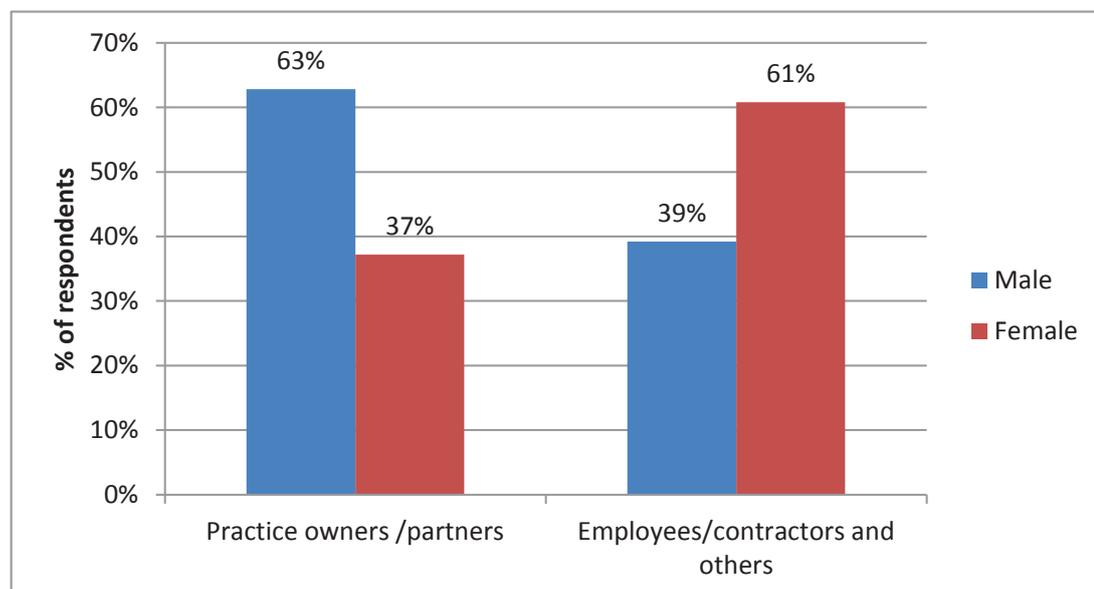


Figure 15 illustrates that the majority of female respondents (72%) were employees or contractors while this proportion was even for males.

**Figure 15: Male and female respondents by employment status**

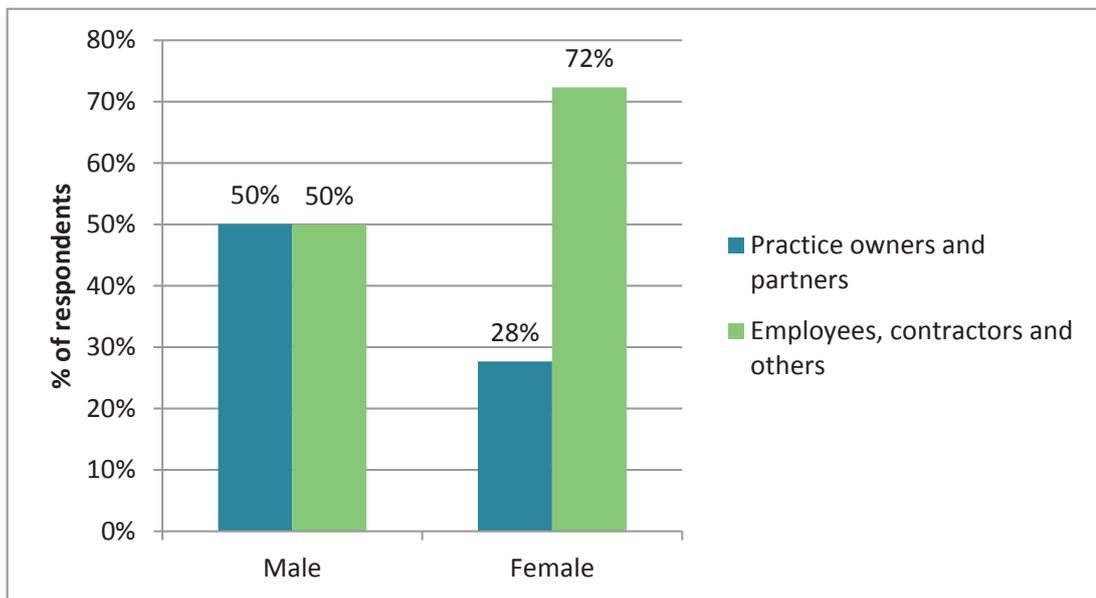
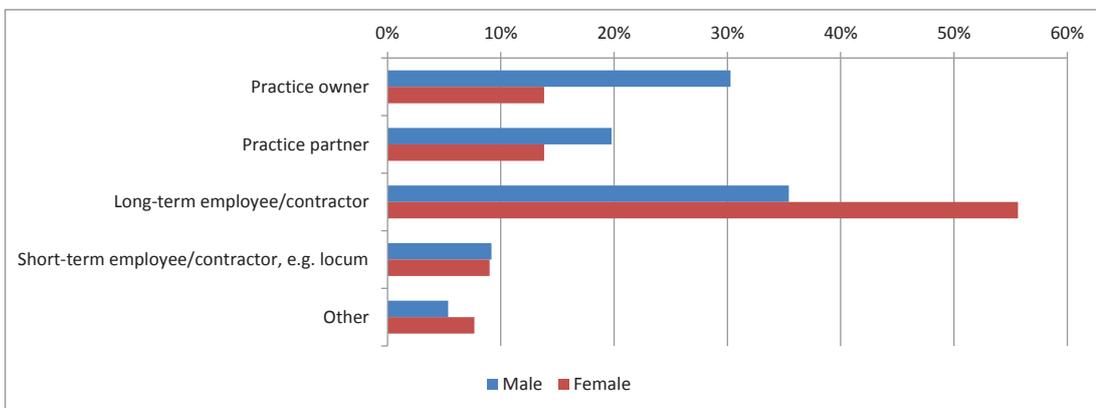


Figure 16 gives a more detailed view of the employment status of male and female respondents. Male respondents were twice as likely to be practice owners as female respondents, with 30% of males owning their practice as opposed to only 14% of females. Males were also more likely to be practice partners, however this difference was less marked than for practice owners.

**Figure 16: Percentages of male and female respondents in each employment category**



Older respondents were twice as likely to be practice owners as younger respondents with 33% of respondents aged 55 and over being practice owners, as opposed to only 16% under 55 years.

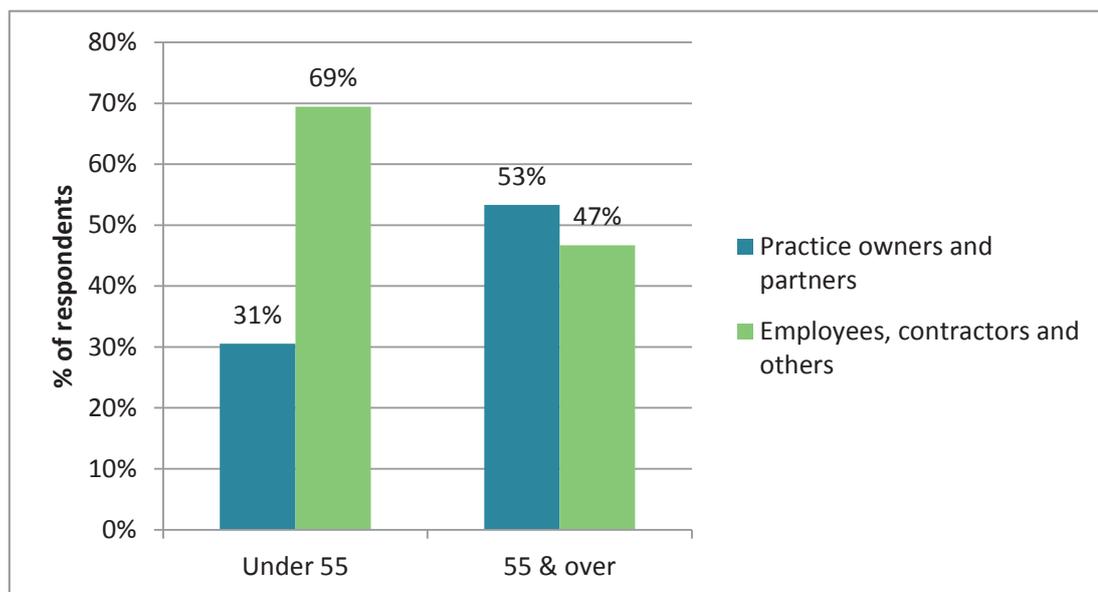
Among contractors and employees, the majority (74%) were aged less than 55 years.

Table 15: Respondents by employment status and age

	Under 55		55 and Over		Total	
	#	%	#	%	#	%
Practice owner	226	16	250	33	476	22
Practice partner	215	15	152	20	367	17
Long-term employee/ contractor	780	54	232	31	1012	46
Short-term employee/ contractor, e.g. locum	113	8	88	12	201	9
Other (please specify)	110	8	32	4	142	6
<b>Total</b>	<b>1444</b>	<b>100</b>	<b>754</b>	<b>100</b>	<b>2198</b>	<b>100</b>

Practice ownership or partnership was higher among older respondents. Figure 17 illustrates that among those respondents under 55 only 31% were practice owners or partners and 69% were employees or contractors. Among those 55 and over 53% were owners or partners and 47% were employees or contractors.

Figure 17: Practice ownership and partnership by age



As noted, female respondents tended to be younger than male. This may go some way to explaining the gender difference in practice ownership. If we compare only those respondents aged 50 years and over, we find that the gender difference, although still obvious, is less marked with 41.6% of older females owning their practice compared to 58.5% of older males. This compares to the difference of 14% of females to 30% of males when all age groups were considered.

## 8.2 Income

In recent years, very little information has been available about GP income, particularly for practice owners and partners. The Medical Assurance Society collects information from member practices on a regular basis, but this is limited to the remuneration of employees and contractors. The College has received numerous requests to provide an update on previously collected income information data. The data collected in this survey provides a valuable insight into the income of New Zealand's GPs.

It should be noted that the income questions and ranges used in this survey differ from those used in previous College surveys, so it is not possible to directly compare these results with earlier surveys.

Respondents were asked 'Which of the following ranges corresponds to your personal annual before-tax income from working in general practice?' Eleven income ranges from \$25,000 or less to \$251,000 or more were provided. This question was not compulsory, however it was answered by the majority of respondents.

Table 16 shows that, as could be expected, the number of hours worked per week was a major determinant of income and consequently the median income band increased as the hours worked increased.

**Table 16: Median income range by hours worked per week**

Hours worked per week	Median income range (000)
20 or less	\$51 — \$75
21-35	\$101 — \$125
36-55	\$151 — \$175
More than 55	\$176 — \$200

Table 17 and Figure 18 show the relationship between employment status and income. Practice owners and partners tended to have the highest incomes with 69% and 68% respectively reporting an income more than \$150,000. Owners and partners have governance responsibilities and carry the financial risk and as illustrated in Table 7, they tend to work longer hours than employees/contractors. By comparison, 26% of long-term employees and 17% of short-term employees reported an income more than \$150,000.

**Table 17: Respondent income by employment status**

\$ (000)	Practice owner		Practice partner		Long-term employee/contractor		Short-term employee/contractor e.g. locum		Other	
	#	%	#	%	#	%	#	%	#	%
\$25 or less	2	0	3	1	32	3	20	10	11	8
\$26-50	5	1	4	1	87	9	28	14	8	6
\$51-75	8	2	2	1	141	14	36	18	45	32
\$76-100	21	4	23	6	152	15	30	15	41	29
\$101-125	53	11	37	10	171	17	36	18	8	6
\$126-150	58	12	45	13	155	15	16	8	6	4
\$151-175	54	12	42	12	96	10	14	7	6	4
\$176-200	58	12	53	15	86	9	9	5	5	4
\$201-225	52	11	43	12	39	4	7	4	5	4
\$226-250	56	12	41	11	23	2	1	1	3	2
\$251 or more	101	22	67	19	22	2	2	1	1	1
<b>Total</b>	<b>468</b>	<b>100</b>	<b>360</b>	<b>100</b>	<b>1004</b>	<b>100</b>	<b>199</b>	<b>100</b>	<b>139</b>	<b>100</b>

Figure 18: Respondent income by employment status (\$000)

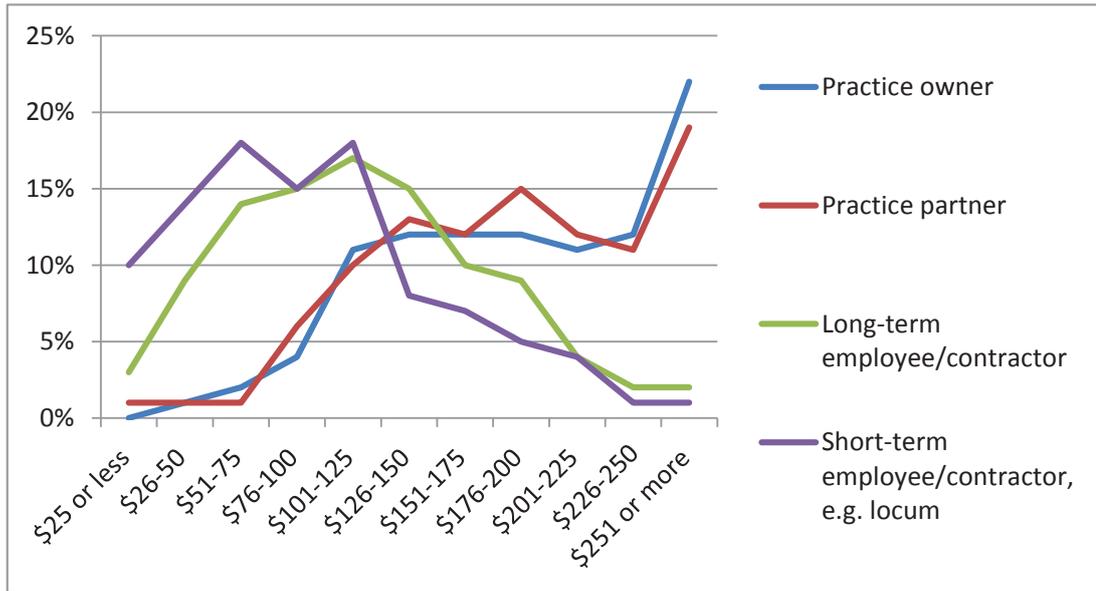


Table 18 and Figure 19 show the relationship between respondents' age and income distribution. Older respondents tended to have a higher income than younger respondents, with 31% of respondents less than 50 years of age having an income more than \$150,000 compared to 51% of respondents aged 50 years and over. Table 15 showed that older respondents were more likely to be practice owners or partners.

Table 18: Respondent income by age group

\$ (000)	Under 50		50 & Over	
	#	%	#	%
\$25 or less	30	3	38	3
\$26-50	79	8	53	5
\$51-75	145	14	87	7
\$76-100	152	15	115	10
\$101-125	167	17	140	12
\$126-150	137	14	143	12
\$151-175	88	9	124	11
\$176-200	76	8	137	12
\$201-225	47	5	99	8
\$226-250	39	4	86	7
\$251 or more	46	5	147	13
<b>Total</b>	<b>1006</b>	<b>100</b>	<b>1169</b>	<b>100</b>

Figure 19: Comparison of income between respondents under 50 years of age and those 50 years or over

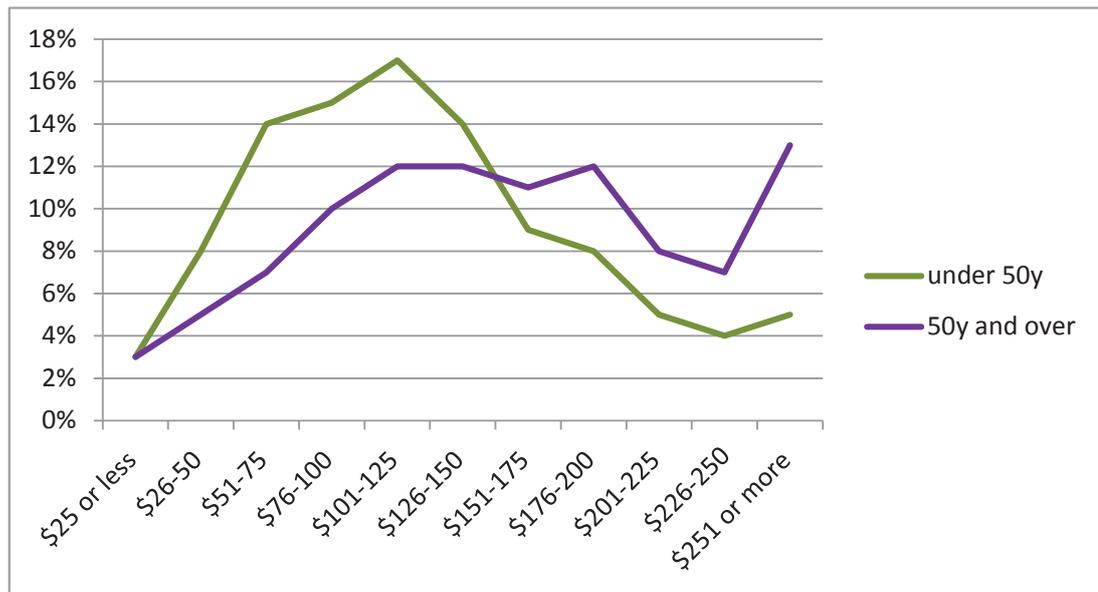


Table 19 and Figure 20 show the distribution of all male and female respondents across the income bands. Male respondents tended to have a higher income than female respondents, with 59% of males reporting a personal pre-tax income from working in general practice of more than \$150,000 per annum compared to 24% of females.

Table 19: Respondent income by gender

\$ (000)	Female		Male		Total	
	#	%	#	%	#	%
\$25 or less	46	4	21	2	68	3
\$26-50	106	10	25	2	132	6
\$51-75	174	16	54	5	232	11
\$76-100	188	17	75	7	267	12
\$101-125	188	17	113	11	307	14
\$126-150	136	12	136	13	280	13
\$151-175	77	7	133	13	212	10
\$176-200	78	7	135	13	213	10
\$201-225	40	4	104	10	146	7
\$226-250	28	3	96	9	125	6
\$251 or more	42	4	149	14	193	9
<b>Total</b>	<b>1103</b>	<b>100</b>	<b>1041</b>	<b>100</b>	<b>2175</b>	<b>100</b>

Figure 20: Comparison of income by gender for all working respondents

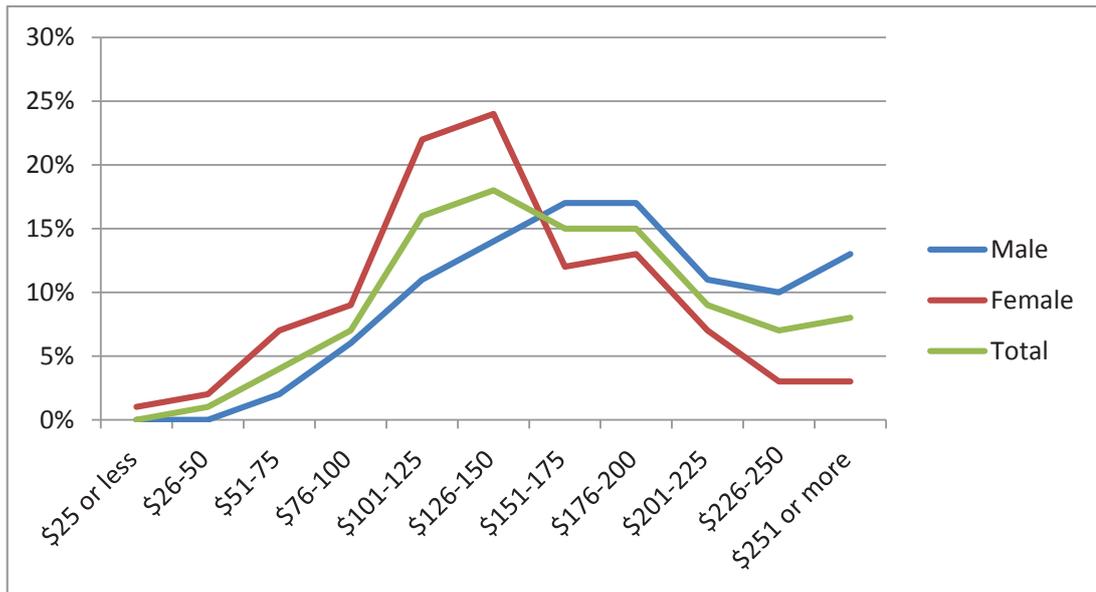


As noted, male respondents tended to work more hours per week than female respondents. In an attempt to allow for this, Table 20 and Figure 21 include only those respondents who reported working 36-40 hours per week.

Table 20: Income by gender for respondents working 36-40 hours per week

\$ (000)	Female		Male		Total	
	#	%	#	%	#	%
\$25 or less	2	1	0	0	2	0
\$26-50	3	2	1	0	4	1
\$51-75	13	7	4	2	17	4
\$76-100	17	9	14	6	31	7
\$101-125	44	22	26	11	71	16
\$126-150	47	24	33	14	81	18
\$151-175	23	12	42	17	65	15
\$176-200	25	13	42	17	67	15
\$201-225	14	7	26	11	41	9
\$226-250	5	3	24	10	30	7
\$251 or more	5	3	32	13	37	8
<b>Total</b>	<b>198</b>	<b>100</b>	<b>244</b>	<b>100</b>	<b>446</b>	<b>100</b>

Figure 21: Comparison of income by gender for respondents working 36-40 hours per week



A difference in income bands remains after controlling for hours worked, with 68% of males having an income more than \$150,000 compared to 36% of females.

To further understand the data, gender income differences were looked at in the employee/contractor and owner/partner employment categories separately.

Table 21 and Figure 22 show that among contractors and employees working 36-40 hours per week, male respondents tended to have a significantly higher income than female respondents with 63% of males having an income of more than \$150,000 compared to only 32% of females.

Table 21: Income of employees and contractors working 36-40 hours per week by gender

\$ (000)	Male		Female		Total	
	#	%	#	%	#	%
\$25 or less	0	0	1	1	1	0
\$26-50	0	0	3	3	3	1
\$51-75	0	0	3	3	3	1
\$76-100	5	4	8	7	13	6
\$101-125	17	14	34	30	51	22
\$126-150	23	19	30	26	53	23
\$151-175	29	24	12	11	41	17
\$176-200	23	19	17	15	40	17
\$201-225	14	12	4	4	18	8
\$226-250	6	5	1	1	7	3
\$251 or more	4	3	1	1	5	2
<b>Total</b>	<b>121</b>	<b>100</b>	<b>114</b>	<b>100</b>	<b>235</b>	<b>100</b>

Figure 22: Gender comparison of income for employees/contractors working 36-40 hours per week

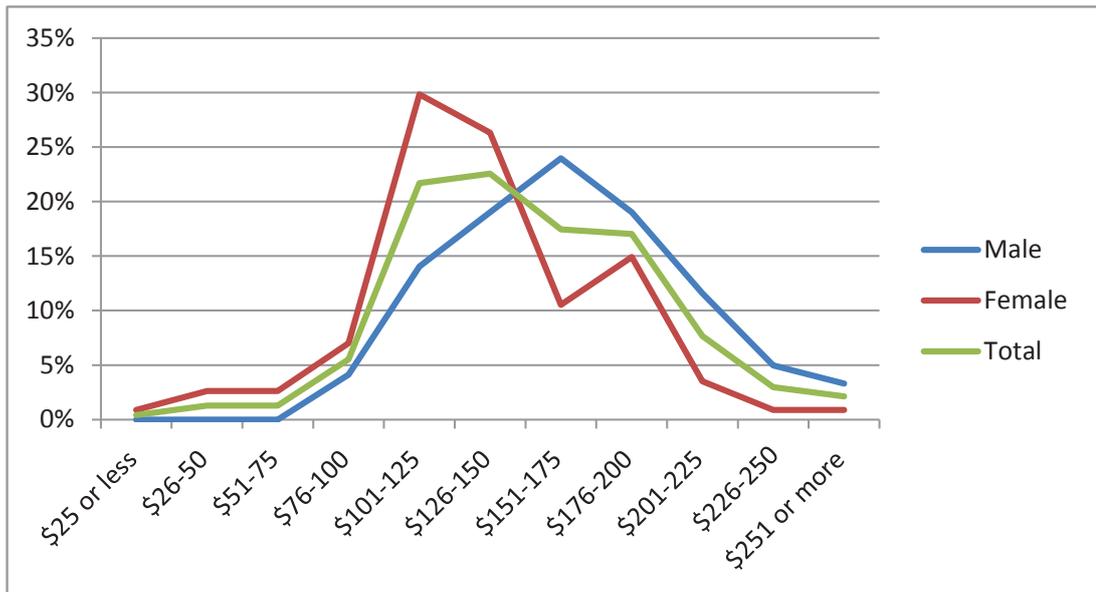
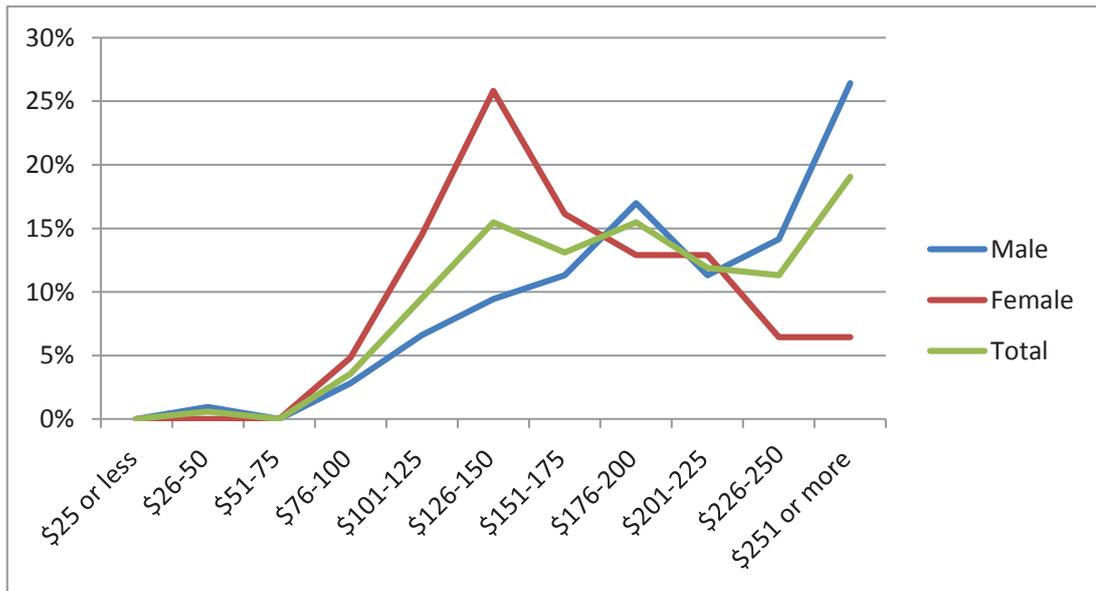


Table 22 and Figure 23 show that among practice owners and partners working 36-40 hours per week, male respondents tended to have a significantly higher income than female respondents with 80% of males having an income of more than \$150,000 compared to only 55% of females.

Table 22: Practice owners and partners working 36-40 hours per week by gender

\$ (000)	Male		Female		Total	
	#	%	#	%	#	%
\$25 or less	0	0	0	0	0	0
\$26-50	1	1	0	0	1	1
\$51-75	0	0	0	0	0	0
\$76-100	3	3	3	5	6	4
\$101-125	7	7	9	15	16	10
\$126-150	10	9	16	26	26	15
\$151-175	12	11	10	16	22	13
\$176-200	18	17	8	13	26	15
\$201-225	12	11	8	13	20	12
\$226-250	15	14	4	6	19	11
\$251 or more	28	26	4	6	32	19
<b>Total</b>	<b>106</b>	<b>100</b>	<b>62</b>	<b>100</b>	<b>168</b>	<b>100</b>

Figure 23: Gender comparison of income of practice owners and partners working 36-40 hours per week



Differences in hours worked and employment status do not appear to account completely for the lower income reported by female respondents.

This New Zealand data is in keeping with the findings of recent Australian research which found that on average female GPs in Australia earn 54% less than male GPs.<sup>11</sup>

### 8.3 Income in rural and urban areas

The median income band for respondents from practices considered rural was higher than that for their urban counterparts. Table 23 shows the median income band for rural respondents was \$151-175,000. This is higher than the range of \$126-150,000 for urban respondents. It is important to bear in mind, however, that rural respondents were more likely to work full-time (67%) than respondents in urban practices (50%).

Table 23: Median and average income by rural and urban areas (all hours worked)

	Rural	Urban	Not clearly urban or rural
Median income band	\$151-175,000	\$126-150,000	\$126-150,000

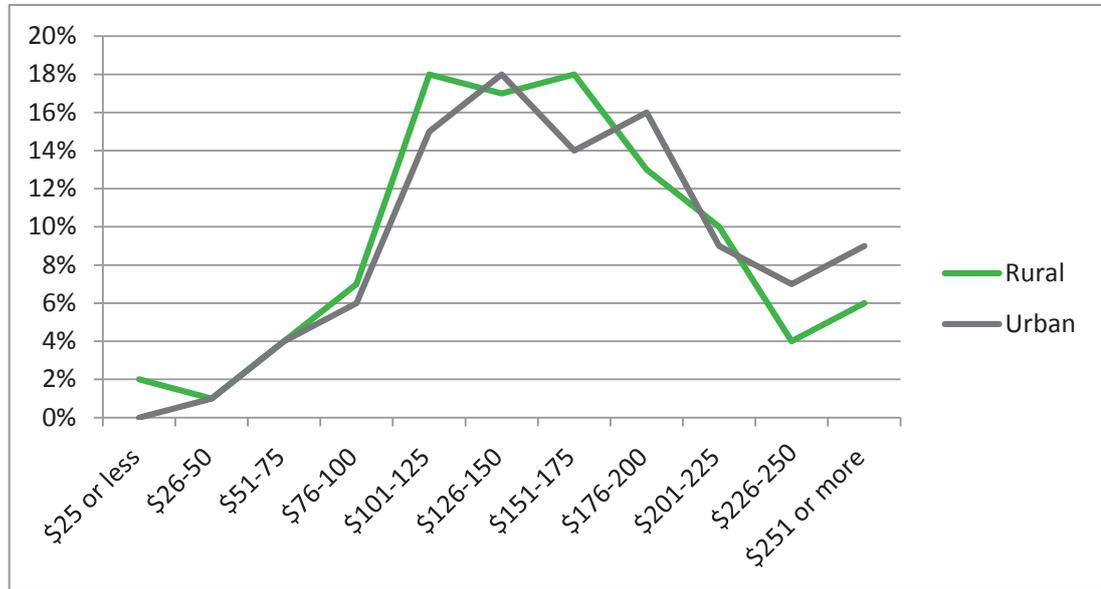
Accordingly we compared the income of those rural and urban respondents working 36-40 hours per week. Table 24 and Figure 24 show that only minimal differences remained in the income of rural and urban respondents with 55% of urban respondents having an income of more than \$150,000 compared to 51% of rural respondents.

<sup>11</sup> Schurer S, Kuehnle D, Scott A, Cheng TC. One Man's Blessing, Another Woman's Curse? Family Factors and the Gender-Earnings Gap of Doctors. Institute for the Study of Labor Discussion Paper No. 7017. November 2012.

Table 24: Income in rural and urban areas for respondents working 36-40 hours per week

\$ (000)	Rural		Urban		Not clearly urban or rural	
	#	%	#	%	#	%
\$25 or less	2	2	0	0	0	0
\$26-50	1	1	3	1	0	0
\$51-75	3	4	14	4	0	0
\$76-100	6	7	21	6	4	13
\$101-125	15	18	50	15	6	19
\$126-150	14	17	61	18	6	19
\$151-175	15	18	46	14	4	13
\$176-200	11	13	52	16	4	13
\$201-225	8	10	30	9	3	9
\$226-250	3	4	24	7	3	9
\$251 or more	5	6	30	9	2	6
<b>Total</b>	<b>83</b>	<b>100</b>	<b>331</b>	<b>100</b>	<b>32</b>	<b>100</b>

Figure 24: Comparison of the income of rural and urban respondents working 36-40 hours per week



## 9 Teachers

Participants were asked to indicate whether they were involved in teaching. This question was answered by 2069 respondents of which 1361 (66%) indicated that they were not involved in teaching, leaving 708 respondents (34%) involved in teaching in some capacity.

Among those 708, many indicated that they had more than one teaching role, hence the percentages in Table 25 total more than 100%. The largest group were the 552 respondents (78% of all involved in teaching) who were teaching undergraduate students.

*Table 25: Respondents involved in teaching - involvement in providing general practice education*

	#	%
I am a General Practice Education Programme (GPEP) Year 1 teacher	143	20
I am a medical educator in GPEP	87	12
I teach doctors in the Postgraduate Generalist Placement Education Programme	76	11
I supervise a registrar in GPEP Year 2 or Year 3	134	19
I teach undergraduate medical students	552	78

Notably, rural respondents were more likely to be teachers than their urban colleagues. Among respondents who considered they worked in a rural practice 65% were involved in teaching in some capacity. Among urban respondents this figure was 36%.

## 10 District Health Boards (DHB)

### 10.1 Demographics by DHB

In general, the number of responses from each DHB was in proportion to the size of that DHB although for some – Whanganui, Lakes (Taupo and Rotorua), South Canterbury, MidCentral and Auckland in particular – the number of responses was lower than expected.

The survey revealed considerable variation between DHBs in the age and gender of respondents. Table 26 shows that in Capital & Coast and Nelson Marlborough DHBs, 63% of respondents were female, the highest proportion of any of the DHBs. At the other extreme was the West Coast where only three (20%) respondents were female. MidCentral, which had more respondents, still only had 15 (32%) female GPs. Overall, 1119 (52%) respondents were female. A further 81 respondents did not indicate their DHB classification or gender.

*Table 26: Gender by DHB*

DHB	Female		Male		Total
	#	%	#	%	#
Capital & Coast	105	63	62	37	167
Nelson Marlborough	56	63	33	37	89
Waitemata	126	61	82	39	208
Canterbury	163	58	116	42	279
Hutt Valley	31	57	23	43	54
South Canterbury	10	56	8	44	18
Auckland	146	55	118	45	264
Taranaki	24	50	24	50	48
Wairarapa	6	50	6	50	12
Southern	86	48	92	52	178
Bay of Plenty	50	46	59	54	109
Counties Manukau	91	46	107	54	198
Hawke's Bay	38	46	44	54	82
Lakes	19	44	24	56	43
Waikato	84	44	108	56	192
Tairāwhiti	7	41	10	59	17
Northland	32	39	51	61	83
Whanganui	8	35	15	65	23
MidCentral	15	32	32	68	47
West Coast	3	20	12	80	15
Other (locums, multiple locations etc.)	19	58	14	42	33
<b>Total</b>	<b>1119</b>	<b>52</b>	<b>1040</b>	<b>48</b>	<b>2159</b>

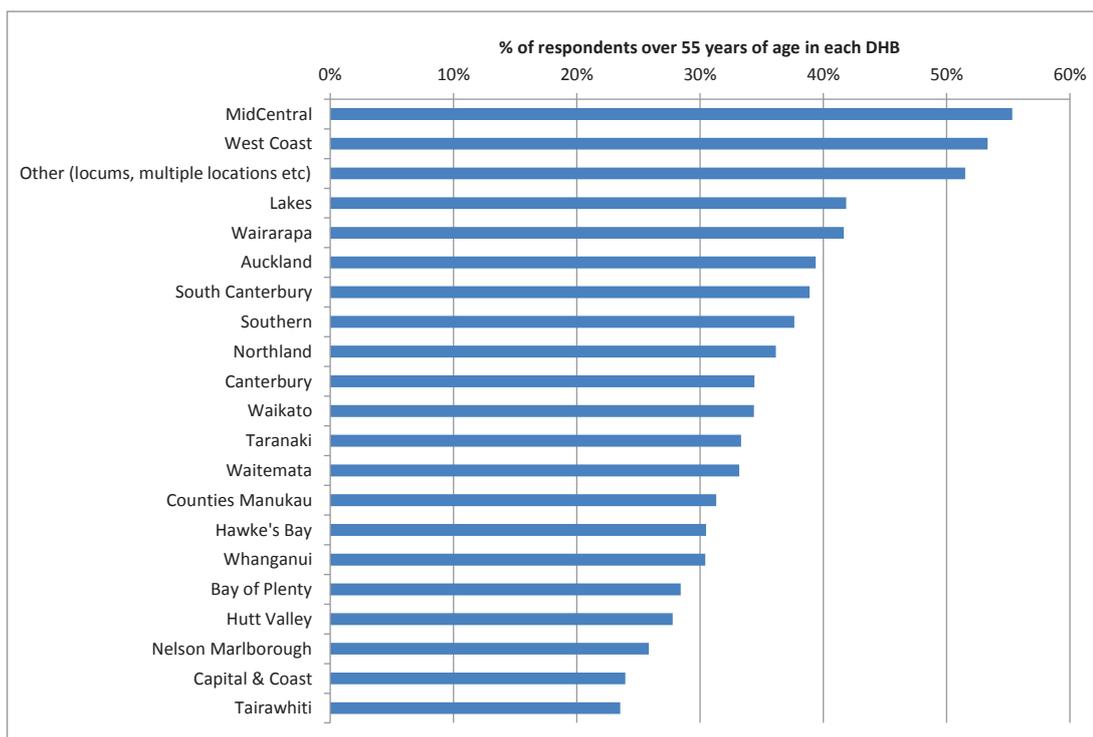
The age of the workforce in DHB areas varies widely, with some DHBs having more than twice the proportion of respondents aged over 55 as others. Table 27 and Figure 25 show how DHBs are ranked regarding the proportion of respondents from their DHB aged over 55. At 55%, MidCentral had the highest proportion of respondents aged 55 and over.

Respondents from Tairāwhiti and Hutt Valley DHBs had the lowest average ages with 46.6 and 46.9 years respectively. Tairāwhiti, at 24%, also had the lowest proportion of respondents aged 55 and over.

**Table 27: Respondents aged 55 and over by DHB**

<b>DHB</b>	<b># of respondents aged 55 and over</b>	<b>% of respondents aged 55 and over</b>
MidCentral	26	55
West Coast	8	53
Lakes	18	42
Wairarapa	5	42
Auckland	104	39
South Canterbury	7	39
Southern	67	38
Northland	30	36
Canterbury	96	34
Waikato	66	34
Taranaki	16	33
Waitemata	69	33
Counties Manukau	62	31
Hawke's Bay	25	30
Whanganui	7	30
Bay of Plenty	31	28
Hutt Valley	15	28
Nelson Marlborough	23	26
Capital & Coast	40	24
Tairāwhiti	4	24
Other (locums, multiple locations etc.)	17	52
<b>Total</b>	<b>736</b>	<b>33</b>

Figure 25: DHBs by the % of respondents aged over 55 years



## 10.2 Current and intended working hours by DHB

There was considerable variation between DHBs in the proportions of respondents working part-time or working particularly long hours.

Table 28 shows that those DHBs with highest proportions of respondents working over 55 hours per week included Tairāwhiti (18%), South Canterbury (17%), MidCentral (15%), Northland (14%) and Whanganui (13%). The DHBs with the lowest proportion of respondents working more than 55 hours per week were Nelson Marlborough (3%), Counties Manukau (4%) and Hutt Valley (5%).

As noted, across New Zealand 46% of respondents were working part-time (here defined as less than 36 hours per week). In some DHBs the proportion was much higher. For example, in Capital & Coast DHB, 60% of respondents were working part-time, while Nelson Marlborough (57%), Bay of Plenty (54%) and Canterbury (53%) were not far behind. The percentage working 20 hours per week or less also varied, from none in West Coast to 22% in Capital & Coast.

Such significant differences in hours worked underscore the need to consider FTEs rather than headcounts when making comparisons between the ratio of GPs to population in different DHBs.

Table 28: Working hours by DHB

DHB	20 or less	21-35	36-55	More than 55	# of respondents
Auckland	20	29	44	7	268
Bay of Plenty	14	40	40	6	109
Canterbury	20	33	41	6	283
Capital & Coast	22	38	34	7	168
Counties Manukau	11	27	57	4	201
Hawke's Bay	15	27	47	11	85
Hutt Valley	16	31	47	5	55
Lakes	19	19	53	9	43
MidCentral	8	33	44	15	48
Nelson Marlborough	17	40	40	3	90
Northland	5	31	51	14	85
South Canterbury	6	17	61	17	18
Southern	13	33	49	6	183
Tairāwhiti	18	12	53	18	17
Taranaki	10	31	53	6	49
Waikato	11	27	55	6	193
Wairarapa	17	25	50	8	12
Waitemata	14	30	48	7	211
West Coast	0	33	60	7	15
Whanganui	17	13	57	13	23
DHB not indicated	8	35	50	8	26
Other situations (please specify)	30	30	39	0	33

Table 29 ranks the DHBs by the proportion of GPs intending to work fewer hours per week in five years' time. The effect of age can be seen clearly with those DHBs with older respondents also tending to have higher proportions intending to decrease their hours.

Those DHBs with a higher proportion of doctors working 36 hours or more were more likely to also have a higher proportion of respondents who indicated that they intended to work 'fewer hours per week' in the next five years.

In a similar vein, Nelson Marlborough and Capital & Coast had the highest proportion of doctors who indicated that they intend to work 'more hours per week' in five years, with 20% and 18% respectively.

**Table 29: Intended changes in working hours in five years' time by DHB (%)**

<b>DHB</b>	<b>Fewer hours per week</b>	<b>A similar number of hours per week</b>	<b>More hours per week</b>
West Coast	50	43	7
Northland	48	48	4
South Canterbury	47	41	12
Wairarapa	38	50	13
Auckland	37	49	14
MidCentral	37	54	10
Hawke's Bay	36	54	10
Waikato	36	57	7
Waitemata	34	53	13
Tairāwhiti	33	53	13
Grand Total	32	56	12
Hutt Valley	31	65	4
Bay of Plenty	31	61	8
Counties Manukau	30	62	8
Whanganui	30	65	5
Lakes	30	57	14
Southern	30	59	12
Capital and Coast	29	53	18
Canterbury	28	57	16
Taranaki	21	79	0
Nelson Marlborough	20	59	20
Other situations	29	63	8

Not all DHBs will be similarly affected by the retirement of the respondents in the older cohort. Table 30 suggests that if respondents adhere to their current intentions, then MidCentral, West Coast and Lakes DHBs are at particularly high risk of a decline in the supply of GPs. The relative situation for individual DHBs varies depending on what time interval is considered. For example, although Whanganui appears to be less severely affected than many DHBs with only 32% intending to retire within the next 10 years, if a 15-year time span is considered then this increases from 32% to 64%.

We anticipate that DHBs will find this information useful in informing their future planning.

**Table 30: Proportion of respondents intending to retire within 10 years by DHB**

<b>DHB</b>	<b>% intending to retire within 10 years</b>
MidCentral	50
West Coast	47
Lakes	45
Wairarapa	42
Auckland	41
Bay of Plenty	41
South Canterbury	39
Southern	39
Canterbury	38
Northland	38
Hawke's Bay	36
Tairāwhiti	35
Taranaki	35
Waitemata	35
Hutt Valley	33
Waikato	33
Counties Manukau	32
Whanganui	32
Nelson Marlborough	30
Capital & Coast	25

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